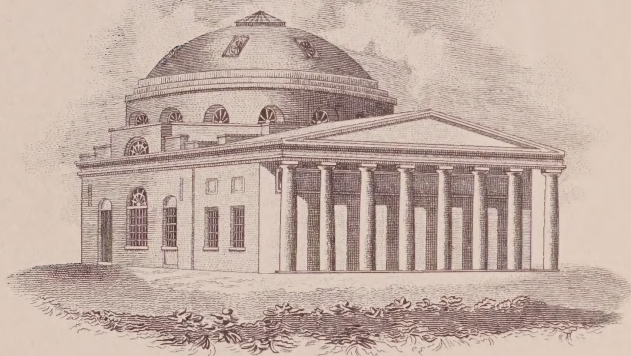


LIBRARY
OF THE
School of Medicine



University of Maryland

Issued Quarterly

Price \$1.00 per year.

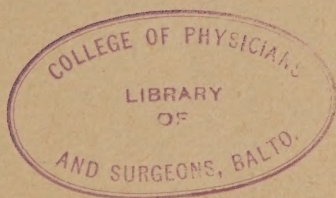
THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS
BALTIMORE.

Vol. IV

No. 1

APRIL, 1901

PUBLISHED AT
Baltimore and Eutaw Sts. Baltimore, Md



41
7225 ✓

GIVES BEST RESULTS

MULFORD'S ANTITOXIN

PHILADELPHIA, CHICAGO

H. K. MULFORD
COMPANY
CHEMISTS

Mulford's Glycerinized Vaccine

115
is prepared with every possible aseptic precaution. Each separate yield is subjected to the most rigid tests. It is guaranteed to succeed in 100 per cent. of primary cases, and retains its activity at least six months.

The virus from absolutely healthy animals only is employed, and each separate yield is subjected to the most rigid Physiologic and Bacteriologic tests.

H. K. MULFORD CO.

Chemists

PHILADELPHIA

CHICAGO

Case of 10 tubes—10
vaccinations—\$1.00.
Mailed upon receipt
of price. Write for
literature.

The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,
CATONSVILLE, Md.

REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
Rohé as Man and Friend. DR. W. SIMON,	1
Reducing Agents in the Urine. DR. A. McGLANNAN,	9
The Nasal Septum in Relation to the Human Economy in Health and Disease. DR. J. WILLIAM WATSON,	13
Skin-Grafting. JOHN B. McMURRAY,	19
Editorial,	25
Personal Notes,	iv, v, 26
Correspondence,	29

IN CYSTITIS

and all inflammatory conditions of the urinary tract, difficult and painful micturition, wetting of the bed and wherever a demulcent diuretic is indicated

LITHIATED SORGHUM COMP. IS AN INFALLIBLE REMEDY

as the testimony of thousands of physicians bears evidence. It has acted in many instances where other remedies have failed to alleviate the condition of the patient or cure the disease. It possesses a pleasant, palatable taste and produces no cumulative or other undesirable effects. Its value depends upon the formula

AND CONTAINS

R	Broomcorn Seed (<i>Sorghum Saccharatum</i>)	
	Corn Silk	}
	Saw Palmetto	
	Hydrangea	
	Lithium Benzo-Citrate	16 grains.
	in each fluid ounce.	

Literature and Samples gladly furnished on application.

SHARP & DOHME LABORATORIES,

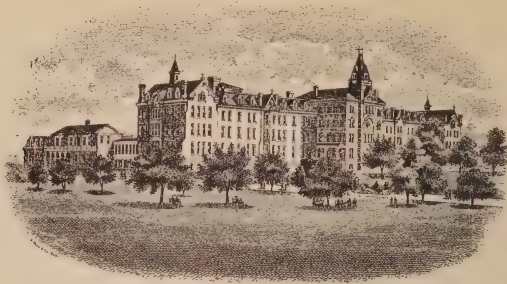
BALTIMORE, MD.

General Offices, 41 John Street, New York, N. Y.

Western Branch, 221 Randolph Street, Chicago, Ill.

Southern Branch, 422 Gravier Street, New Orleans, La.

ST. AGNES' SANITARIUM.



This Institution is beautifully situated on high, rolling ground, just outside Baltimore, and overlooking the Bay. It is thoroughly equipped as a modern Sanitarium for the treatment of Nervous Diseases and Drug Habits (no mental cases received). A complete Hydrotherapeutic Establishment has been recently added. Electric outfit, Gymnasium, Massage by trained operators, Sun Parlors, Billiard Rooms, Tennis, Golf, &c.

Medical Director, George J. Preston, M. D., Professor of Nervous Diseases, College of Physicians and Surgeons, Baltimore.

For further information, terms, &c., address

THE SISTER SUPERIOR,

St. Agnes' Sanitarium, Carroll P. O., Baltimore, Md.

Personal Notes.

DR. J. F. HUSTLER, '86, died at New Kensington, Pa., in July, 1900.

DR. H. DEWITT SHANKLE is now located at Saludo, Polk County, N. C.

A CARD.

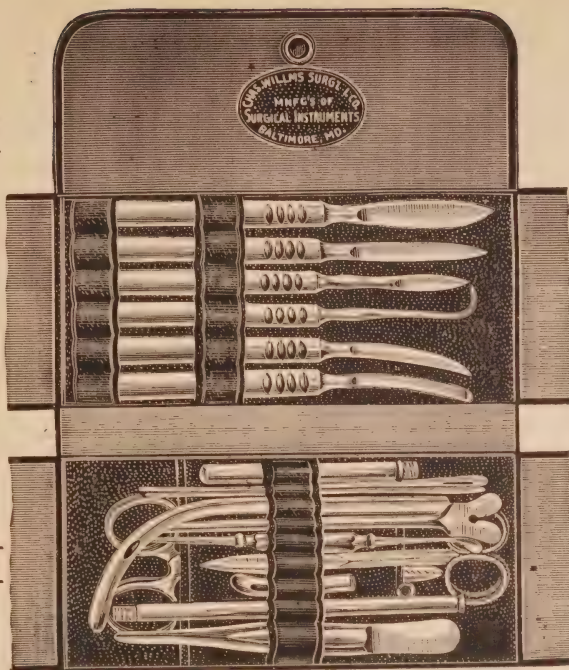
At the beginning of another season, we beg physicians to consider the advisability of sending more of their patients to us for prescriptions and sick-room supplies. We will waive matters of ethics and base our claims for additional patronage upon the excellent character of our work, the better results secured through concentrated efforts and upon the advantages a comprehensive stock gives us.

MICROSCOPICAL AND
CLINICAL SUPPLIES.

HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

**"OUR
LEADER."**

Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.



All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,

BENJ. A. NELSON, General Manager,

MANUFACTURERS AND IMPORTERS,

300 N. HOWARD STREET, - - - BALTIMORE, MD

PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES.

CLINICAL LABORATORY OF

DR. HUBERT C. KNAPP,

(Demonstrator Clinical Laboratory College of Physicians and Surgeons.)

1227 NORTH CENTRAL AVENUE,

BALTIMORE, MD.

*Examinations of Urine, Gastric Juice, Blood and Sputum will be made for
Physicians in general practice.*

*Instructions for the preparation and preservation of specimens will be sent
upon request. Terms upon application.*

Personal Notes.

DR. W. M. LIVSEY, '94, has a flourishing practice at Tunnelton,
W. Va.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

Dear Doctor and Fellow Alumnus:—We solicit your aid in making a collection of the writings of the late Dr. George H. Rohé. If you have any reprints of his articles and are willing to send them to the subscriber to be bound in book form with others we have, we will appreciate your assistance and give the proper credit. Please give the titles of the reprints you have and your address on a postal card, directed as below and we will send the necessary stamps if we do not possess a copy of the reprint named. You will greatly oblige, and assist in putting in permanent shape the writings of this gifted man and beloved teacher.

Fraternally yours, WILLIAM J. TODD,

Baltimore, Md.

Postal Station No. 202,

BLICKENSDEFFER TYPEWRITER.

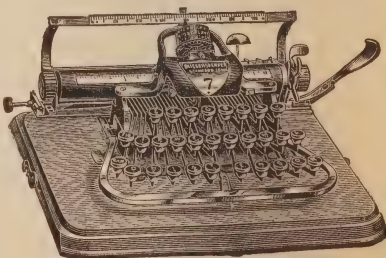
Portable.—Durable.—Invincible.

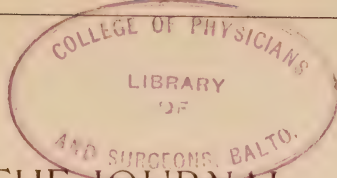
Do you wish to save an enormous amount of time, labor and money and have your correspondence business-like? If so buy a typewriter, and before buying any investigate the BLICKENSDEFFER. It is the only Strictly High Grade, Fully Guaranteed Typewriter at Reasonable cost on the market.

Send for Illustrated Catalogue and Testimonials.

MOORE BROS., General Agents,

NATIONAL UNION BUILDING, WASHINGTON, D. C.
222 E. BALTIMORE ST., BALTIMORE, MD.





THE JOURNAL

OF THE ALUMNI ASSOCIATION OF THE COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

ROHÉ AS MAN AND FRIEND.*

BY DR. W. SIMON.

When a professional man rises far above the average of his associates; when he accomplishes more than most of them do; when he is honored by his professional brethren and personal friends not only during lifetime, but also after he has departed from this world, then it is but natural to ask: What were the causes that influenced this man to step to the front, and why does he continue to live in the memory of the many who have known him?

These are the questions which I am expected to answer this evening in regard to him in whose memory this meeting has been arranged, in regard to our departed friend, Dr. George H. Rohé.

Yes, I have known him; known him for nearly a quarter of a century, and while others have been more closely associated with him than myself, yet I had ample opportunities to become well acquainted with him; to observe and study his character. I hope, therefore, to be able to comply with the request of your association to bring before you a picture of Rohé as he stands before our eyes as man and friend, leaving it to another voice to speak of him as physician, writer and teacher.

* An address delivered at the Rohé Memorial Meeting held at the College of Physicians and Surgeons, February 6, 1901.

The causes which generally bring a professional man to the front may be found either in extraordinary mental supremacy, or in external, often altogether accidental, conditions, favoring the success of his career.

In the case of Dr. Rohé it can scarcely be claimed that he was a great genius; on the contrary, he was a matter-of-fact man. Neither was he lifted to the foreground by extra favorable conditions; indeed, he was compelled from boyhood days to rely chiefly upon his own industry and abilities, but he soon learned to force himself well to the front even under adverse conditions. Talents he possessed many, and these he cultivated well and soon learned how to make good use of them.

Among the mental powers which helped him perhaps more than any others I would place in front his extraordinarily good memory, extending practically in every direction, and embracing a memory for facts and figures, names and faces, unimportant incidents, as well as data of moment.

It was this memory which gave him mental control over the minutiae of a number of medical specialties having no other relation to one another than being medical subjects. It was his wonderful memory for names and faces that helped him to address students by name after they had once been introduced to him, or to grasp their hands familiarly even after many years of separation. It was this peculiar faculty (so highly cherished and much cultivated by many politicians) which assisted him considerably in occupying a prominent position in any public meeting, be it of a medical or other nature. Indeed, it may well be claimed that he knew personally more physicians in Maryland, and possibly even a greater number of those of the nation, than did any other man.

Also, it was this good memory which enabled Rohé to read and speak several languages; to use quotations from Goethe and Schiller, or from Rousseau and Lamartine, with as much readiness as from Shakespeare or Mark Twain.

Memory alone, of course, is of little value, as it may do no more than convert him who possesses it into a walking encyclopedia; such

men exist here and there; their knowledge is of little use to themselves or to the world. But Rohé well knew how, where and when to use this precious gift to best advantage. Indeed, it is right here where I desire to emphasize a second mental power he possessed to a high degree, viz., his readiness, his quickness to use and apply any of the many data carefully stored away within the folds of his retentive brain. This power helped much to make him a delightful conversationalist, but it also gave him splendid opportunities to participate in the discussion of topics of different character in public meetings.

As an excellent illustration of this gift to quickly use to advantage anything that would escape the great majority of people, I may refer to an incident that happened during the International Congress of Obstetricians and Gynecologists in Berlin in 1893. Rohé attended this meeting as delegate from this country, and participated in the deliberations, using the German language as best he could. For the last day of the meeting a banquet had been arranged in a large hall, quite celebrated for the magnificent collection of fine horns and antlers decorating the walls. In order to make clear what relation there exists between these horns and what is to follow I ought to say that there is an old German phrase, "shooting a buck," equivalent to "not hitting the mark," *i. e.*, "making a mistake." The phrase originated most likely at the time when, in the German, exactly as in the English language, "buck" designated a he-goat, while now it is used in both languages for any male deer; shooting a buck originally meant shooting a goat, mistaking it for a deer.

Well, when speech-making was in order and Rohé was called upon to respond to a toast, he arose and addressing the assembled guests in his inimitable style, said: "Gentlemen, I was perfectly aware that, during the past few days, I succeeded in shooting many a fine buck, no doubt to the great, though well-hidden delight of those witnessing the performance, but that you should have been so thoughtful and collect the horns and antlers of the fallen deer, and use them as chief ornaments of this hall, is an honor which I fully appreciate."

Of course, this witticism, so splendidly applied by a foreigner,

caused a storm of applause, and added perhaps more to raise Dr. Rohé in the estimation of many than his scientific contributions may have done. I mentioned the incident more especially as well illustrating Rohé's good memory on one hand, and his gift to utilize the proper thought at the proper time.

Taking up another characteristic of Rohé, I have to emphasize his unbounded self-confidence and self-reliance. He always believed in his ability to accomplish anything he set out to do. It was this feature which caused him never to shrink back from any task he undertook, and that he made a success of his many and widely different professional undertakings in nearly every case is now a well-recorded fact. His motto here was: See what others have done in that line and try to do the same thing better.

I well remember a conversation which I once had with Rohé on this subject. I think it occurred when, after the death of our esteemed friend, Dr. Richard Gundry, he applied for the position of Superintendent at Spring Grove Asylum. I took it for granted that a position of such vast responsibilities should be filled by one who had made a special study of diseases of the mind, and who also should have had some experience in the management of such an institution. Such thoughts, however, did not enter Rohé's mind. "If I get the position, I know that I will give satisfaction to all concerned" is what he said to me, and what afterwards he did in reality.

During the same conversation I jokingly remarked: "Doctor, I think you would not hesitate to accept the presidency of the United States." "Assuredly not," said he, "and I would not make a bad President either."

Rohé was a great and rapid reader. His tastes in that respect showed as much versatility as he demonstrated in the selection of so many entirely different medical subjects. He not only looked over intelligently a mass of medical journals and magazines, but he also read works on history, travels, old and new, and fully enjoyed the old classics, as well as fiction of the modern day. I know that he read Sienkiewicz's "Fire and Sword" in two nights, and a few weeks later had on the tip of his tongue all the many unpronounceable Polish, Russian or Lithuanian names with which the book is crowded.

His working capacity was phenomenal. I have known him repeatedly to prepare a paper—and not a bad one either—for a medical meeting, almost at a minute's notice, surely within a few hours from the time he selected his subject. Of course, there may have been but little new matter in these papers, but they contained a full résumé on the work done in that line within recent years, and an intelligent critical discussion of the subject. That these papers could be prepared so rapidly was due to the fact that Rohé knew exactly where to lay his hands on the original articles scattered through the journals, and that he possessed a wonderful gift to separate the really important data from a mass of minor matter.

It has often been said by his friends that Rohé would have made an excellent editor of a daily newspaper, because he had the gift to quickly grasp situations or conditions, analyze them in his mind, and present his thoughts in readable form at short notice.

As a general rule "book-worms" are very apt to lean towards the philosophical or theoretical side of subjects. With Rohé this was rather the opposite; he was thoroughly practical in all his work, and well knew how to make good practical use of any theoretical knowledge. Indeed, it was difficult for him to conceive of theoretical data, without looking for, or finding, practical application somewhere.

Rohé was very prudent, yes, decidedly politic, and had powers that would have made him a good diplomat. I am inclined to think that he sought the acquaintance of men of influence or position, not altogether for social or professional reasons, but also with the view of having their good will in case he should need it. This side of his character is the one which helped him much in receiving official appointments, to obtain ample funds for his work from city or state, and to be on good terms with the leaders of both political parties.

Our friend possessed rare executive abilities, and his powers to systematize and organize were highly developed. This helped him immensely in arranging data and references so as to have them ready when needed for literary work, lectures or other purposes.

But these talents were also of such immense value to him when founding the last of his creations, the Springfield Asylum, of which

it may be said that it stands there as a lasting monument to the greatness of his talent as constructor and executive. Here, for the first time in his life, he had a golden opportunity to demonstrate on a large scale how a well-planned idea, that had largely originated in his own fertile mind, could be successfully carried out for the benefit of mankind. The eminent success of this institution, and of the modern treatment of the patients there kept, are topics that have been discussed so largely in journals and elsewhere that I need not speak of them. However, permit me to quote at least one sentence from an inspection report made on the Springfield Asylum by Dr. Albert L. Gihon in '98. He says: "Here, then, the problem has been solved, so far as human intelligence can do it, of the humane treatment of those unfortunates whose minds have gone adrift. Here amid the placid surroundings of rural life, with agreeable outdoor occupation, the unbalanced mind may recover its equilibrium, or, if that cannot be, if healthy living, wholesome food and generous indulgence cannot effect a cure, the inveterate sufferer can at least live peacefully, decently, and, as far as the fantasies shaped by his seething brain will permit, contentedly."

Dr. Rohé had a strong personality; he could be aggressive where he thought it necessary to be so; he knew well how to defend his convictions, but was ever ready to modify his views when shown to be in the wrong. Similarly, his likes and dislikes were well pronounced. The bicycle, I think, he hated forever, because a wheelman had caused him a serious accident while driving a spirited horse in Druid Hill Park.

The official positions held by Rohé as Health Commissioner of the city, and as Superintendent of State Institutions, necessarily brought him in close contact with politics and politicians. Unfortunately, we know that such contact only too often distorts the vision of those who enter this field in regard to what is right or wrong, honest or dishonest, honorable or dishonorable. Be it said that Rohé never wavered in this direction, that even his antagonists had to give him full credit for sterling integrity in all his dealings.

Dr. Rohé was decidedly broad-minded, taking a liberal view of

matters concerning the slight failings and even misdoings of others. Indeed, "he cultivated a peculiar, whimsical philosophy in which keenness and kindness were about equally mixed."

He was decidedly in favor of the "indeterminate penal sentence idea," in regard to which he expressed himself somewhat like this: "I believe that all sentences should be indeterminate in a general sense. It would be highly illogical to commit an insane person for six months or a year, and it seems equally so to lock up for a specific time a person who is morally sick. A prisoner who shows no evidence that he will cease to be a menace to the community should certainly remain where he can do no mischief; and, on the other hand, there is no common sense in continuing to confine one who has experienced an honest change of heart. I hold, in brief, that an individual who commits a crime should be isolated from the community until competent authorities decide that there is no likelihood of him repeating his offense. Then he should certainly become a member of society instead of a charge on it. All this applies, of course, to a certain class of cases only."

Rohé repeatedly expressed himself as firmly believing that if the State were to spend more money on modern insane asylums, less money need be spent on jails and penitentiaries. In other words, he took the view that in many cases criminals sin on account of a diseased mind.

How ready our friend was to find extenuating circumstances may be shown by the following incident, as told by himself in the summer of 1898:

"Not long ago," he said, "I was a member of a committee appointed to inspect some of the county jails in Maryland. In a small town which was visited, we found a primitive lock-up, containing nine big black negroes and one white man. The white man proved to be a sailor from Sampson's squadron, off on a furlough. He had arrived home a few days before, and, after the time-honored custom of sailormen, proceeded to get gloriously full, much to the horror of the strait-laced villagers. He was arrested, of course, pleaded guilty, paid his fine and immediately got full again. The same results fol-

lowed, but the second fine was so severe that it left him almost strapped, and he decided to return at once to his ship. That night, however, the news of Cervera's overwhelming defeat reached the town, and Jack felt obliged to celebrate. His jag, we were told, was something really phenomenal, and when hauled up before the court he hadn't a copper to his name. So they sent him up for sixty days. Now, mark the palpable injustice of that proceeding," continued Dr. Rohé with twinkling eyes. "The first two drunks were without special palliation, but he went scot free, because he had money; the third drunk, inspired by the purest patriotism, caused him to be caged like a felon, not because he was jagged, but because he was broke. I made a brief address to my fellow committeemen, put something in my hat and passed it around. When it came back it contained Jack's fine and enough more to send him on his way rejoicing, and, I must admit, thoroughly unrepentant."

I have as yet not spoken of Rohé's social and sociable qualifications and relations to his friends, and yet these formed one of his greatest charms. He was noted for his cordiality, for his conversational powers and his ready wit. His broad culture made him a congenial and much sought-for companion to the most cultivated and refined, wherever he went. Like many other great men, he fully enjoyed the pleasures of the festive board. Both the delicacies of the French cook and the treasures of the wine-cellar found in him a most competent and appreciative judge.

To have seen him at his best one should have met him as presiding officer or toastmaster at a festive gathering of congenial and intellectual friends. Then his varied mental powers, his versatility, his witticisms, shone forth in a multitude of sparkling combinations that were the delight of those present.

Though Rohé made friends wherever he went, one should have entered his home, should have rested at his fireside and broken bread at his table, in order to appreciate fully his kind nature, his congenial spirit, his liberal views. Here, in the midst of those nearest and dearest to his heart, he took delight in accepting the rôle of "mine host." Here, as elsewhere in his doings, liberality was the

guiding star. Money to him was of no value except as a means to provide, besides necessities, those delightful pleasures and treasures of high order which add so much to the real enjoyment of life. He often remarked that he was very glad never to realize that there are 100 cents to the dollar; or at other times he would quote Bob Ingersoll's phrase: "I would rather be poor and spend a dollar like a prince, than be a prince and spend a dollar like a pauper."

I may not commit an indiscretion if I illustrate this side of his character by relating an incident that happened on that last trip to New Orleans, from which our friend never returned to our midst.

There, in the Sunny South, the magnificent flowers were the delight of his little daughter, the only child he possessed, and spending money rather lavishly, the kind father and husband bestowed the finest and choicest flowers on his two companions. Mrs. Rohé tried to remonstrate, but the answer which followed, and which was thoroughly characteristic of the man, was: "I wish to teach our child to value a flower more highly than a dollar."

Such was the man as I have known him. In him, there was taken from us the esteemed colleague whose wise counsel added much to the strength of our faculty; in him, the students lost a gifted teacher; and in him, the medical profession mourns one of its ablest exponents.

The world would be better off if we had more men like George H. Rohé.

REDUCING AGENTS IN THE URINE.

BY DR. A. McGLANNAN, '95.

Reducing substances occurring in the urine are of particular interest, because of the occurrence of glucose in the excretion as a symptom of diabetes. The tests to distinguish that sugar from other reducing agents are of importance, on account of the many errors in diagnosis resulting from a confusion of all reducing substances with glucose.

The various reducing agents occurring in urine fall into one or the other of the following classes:

1. Products of normal metabolism.
2. Products of food impurities.
3. Substances due to food impurities not changed in the organism.
4. Products elaborated by the organism, as protectives against drugs or food impurities.
5. Products secreted only by certain individuals (idiosyncrasy).
6. Materials not connected with metabolism, but the result of decomposition in the intestine.
7. Products of disturbed metabolism.
8. Substances occurring pathologically.

In classifying according to the above scheme, it must be remembered that certain substances may fit into one, two or more groups, and that substances which, occurring in normal quantity cause no confusion, may be excreted in sufficient quantity to give rise to considerable annoyance.

Of the first group, uric acid and creatinin may be excreted in sufficient quantity to reduce Fehling's solution. They are easily distinguished from glucose by not reducing bismuth, not forming an osazone with phenyl-hydrazine, not fermenting with yeast, and not possessing optical activity. From each other they are distinguished by Weyl's reaction for creatinin.

Many substances fall into one or more of the next three classes, and to avoid needless repetition these three classes will be considered together.

The pentoses, xylose and arabinose are often taken into the body in the food, particularly in fruits, and pass rapidly into the urine. In the urine of persons addicted to the morphine habit, considerable pentose is frequently found. Normally, the quantity taken with the food is not sufficient to interfere with the reduction tests for sugar, but on a diet rich in pentoses, enough to cause confusion may be secreted. The pentoses reduce Fehling's solution, are dextro-rotatory, and, with phenyl-hydrazin, form osazones very unlike the osazone of glucose. They do not markedly affect bismuth, and do not ferment with yeast.

Glycuronic Acid.—Various paired glycuronic acids occur in the

urine; the free acid is never excreted, but always a conjugate form. In rare cases it is excreted in conjugated combinations with indoxyl and other putrefactive compounds in sufficient quantity to interfere with the recognition of glucose. As a rule, it is found in the urine in large quantity, as campho-glycuronic acid, or as urochloralic acid, after the ingestion of camphor or chloral hydrate.

All forms of glycuronic acid reduce Fehling's solution and bismuth and form the same osazone. Free glycuronic acid is dextro-rotatory, but the conjugate forms are all lævo-rotatory. These acids do not ferment with yeast.

In the fifth class we find the alkaptonic acids. These acids are two in number—homogentismic and uroleucinic. The exact significance of their secretion is unknown. Both seem to be formed from tyrosin by abnormal putrefaction in the upper portion of the intestine. They reduce Fehling's solution but do not reduce bismuth; do not form an osazone, nor ferment with yeast, and are optically inactive.

Of the many materials resulting from putrefaction in the intestine, pyrocatechin alone is likely to be confused with sugar.

Pyrocatechin occurs after exclusive vegetable diet in conjugation with sulphuric acid. This compound reduces Fehling's solution, but does not resemble sugar in any other reactions.

In the next class we include allantoin, lactose and that form of glycosuria known as alimentary glycosuria.

Allantoin occurs in the urine in considerable quantity during the first week of extra-uterine life and in the urine of pregnancy. It reduces Fehling's solution, but does not resemble grape-sugar in any other reactions.

Lactose occurs in the urine during lactation; it resembles grape-sugar in reducing Fehling's solution, and bismuth in forming an osazone and in optical activity, but differs in not being fermentable with yeast.

In alimentary glycosuria, the sugar present in the urine is glucose, and of course gives all the reactions of that sugar. The condition is diagnosed from diabetes by the disappearance of the sugar from the urine when the carbohydrate diet is restricted.

Pathologically, glucose occurs in the urine in diabetes. It is recognized by reducing Fehling's solution and bismuth, forming an osazone, being dextro-rotatory and completely fermenting with yeast.

In summing up the various tests given for these reducing substances, it will be noticed that the only test that distinguishes glucose from the others is the fermentation with yeast. This is, of all, the most uncertain.

The formation of gas on incubation of urine and yeast cannot be looked on as positive evidence of the presence of glucose. Several check tests have been recommended to overcome this difficulty, but require considerable apparatus and more care than most physicians will give. The disadvantage is obviated by estimating the quantity of reducing substance present and fermenting a portion of the urine in a beaker for 12 hours. At the end of this time, if the reduction be due to glucose, the reducing substance will be greatly diminished in quantity or completely destroyed.

At first glance, bismuth seems to be a better reagent than Fehling's solution. This, however, is not the case. Unoxidized sulphur, which occurs very often in considerable quantity in the urine, will produce a black sulphide of bismuth, not to be distinguished, by the eye, from the reduced bismuth oxide. The fact that Fehling's solution is not reduced by solutions representing .2 per cent glucose prevents the reduction of this reagent by normal urine, which has a reducing power of about .15 per cent. Nylander's bismuth solution is reduced by .05 per cent of sugar. The sensitiveness of the reagents toward uric acid is reversed, Nylander's solution being reduced only by large quantities of this substance. The proper method of making the reduction reactions is to examine first with Fehling's solution, and if a reduction occurs, then examine with bismuth. Should both metallic substances be reduced, the fermentation test should be applied. For reactions to differentiate the various non-fermentable reducing agents occurring in the urine, the reader is referred to the various text-books and laboratory manuals on physiological chemistry.

THE NASAL SEPTUM IN RELATION TO THE HUMAN
ECONOMY IN HEALTH AND DISEASE.

BY DR. J. WILLIAM WATSON, '00.

That nasal respiration goes hand-in-hand with perfect health is a fact that cannot be denied. The nasal septum here plays an important part, inasmuch as it forms the inner walls of the nasal fossæ, and is more or less associated with some eight bones of the head and face.

Without going into anatomical details, it is well to remember that the septum is made up of a cartilaginous and a bony portion, both of which give the nose its shape in part and keep the nares patent. Their complete destruction is apt to lead to an ugly deformity; sometimes observable in cases of advanced syphilis. Hence, in operations on the septum, it is always necessary to take care to prevent its destruction from sloughing, necrosis, or any other cause.

Aside from the cosmetic effect, the absence of a septum might be construed as an advantage leading to more air space, and, hence, a better ventilation of the naso-pharynx, the ear, and the accessory sinuses. However, when the septum is gone, one of the mainstays and props to the nose is removed. We have a large open cavity, with somewhat flabby walls which are liable to collapse, and under the influence of inflammation and disease to form adhesions and synechias leading to stenosis. Then, too, a foreign body would have an easy access, and instead of one naris being obstructed, the whole might be and the patient would have resort to mouth breathing, baleful in its effects, while the septum complete to the philtrum would ward off the foreign body or permit only one nostril to be occluded.

The septum assists greatly in the important part of olfaction and protection. Olfaction, because the filaments from the olfactory nerve are distributed on its sides, forming one-third of the area with which to perceive the odor of gases. This makes the septum closely related to the sense of taste, since it and olfaction are associated. Protection, by sensation and olfaction. The septum, as well as other parts of the nose, is well supplied with sympathetic and sensory nerves. By its sensitiveness to touch it prevents injurious substances from

gaining admittance, or, by producing the reflex action of sneezing, causes their expulsion. The entrance of irritating substances causes at first a cessation of inspiration, followed by a forcible expiration to remove the offending material. Olfaction protects the body from injurious air, gases and food, and gives some of the lower animals, as the deer or rabbit, a means of self-preservation.

It seems, then, that the septum in health occupies an important position in the human organism. The writer does not pretend to be giving anything new and does not wish to go on record as affirming that the septum is necessary to life or to a certain degree of health. The records will show quite a number of cases which have lived with a comparative degree of comfort with part or all of the septum removed, the sense of olfaction, however, being somewhat impaired.

On the other hand, the diseased septum is worthy of considerable attention, since its morbid results may be widespread in the human organism. By the term disease we mean any abnormal condition of the septum from the epidermis above the philtrum back to the choanæ. That disease is common here is shown by the remarkable fact that about one-fourth of all patients whose noses are examined show some abnormality of the septum. Oftentimes patients are not aware of any trouble in the nose. They come complaining of throat trouble, chiefly hawking and spitting; it may be impaired hearing, or, less often, it may be some eye trouble. When the trouble is eczema, ulcer, perichondritis, tumor, or abscess of the septum the symptoms become subjective, the patient seeking the physician for relief from pain. Cases of hypertrophy and deviation may not call the patient's attention to his condition unless narrowing and stenosis of the nares ensues. Such morbid conditions are sufficiently well aired in the text-books, and nothing further need be said except that they are diseases requiring treatment which are, for the most part, rare as compared with ecchondroses, exostoses, spurs, or ledges.

During the last three years these growths have claimed more attention than formerly. This is commendable from the fact that these cases are more frequent than the laity have any idea of. Out of about 5000 throat cases examined during this time 1000 septums

showed their presence.* No doubt many people have them (septal spurs) and are never aware of it from the fact that they cause no trouble. From the writer's observation during the past year on septums of people in good health with no complaints, he feels safe in saying that probably about one-fifth of the people have this deformity on their septum.

They might be defined as cartilaginous or osseous tumors which may be seen as protuberances on the septum covered with septal mucous membrane. They may be low down near the floor of the nose, or they may be high up and back on the septum, and may occupy the greater part of the middle meatus. They vary in size from a mere pointed thickening to one almost occluding the nares. It cannot be said that any age is absolutely free from them. No doubt many are congenital, associated with strumous conditions, increasing in size as age advances. Probably many are due to increased nutrition in the part, a cause similar to that producing hypertrophy of the pharyngeal tonsil, but it is not known that they, like adenoids, atrophy with age. Under the microscope they show mucous membrane, osseous or cartilage cells according to their location.

The sequelæ of these growths are numerous, depending upon their size. Many ills are charged to the nose, and no doubt "spurs" could be blamed for a great many, since they occur three times more frequently than any other trouble of the septum, and about twice as often as chronic catarrhal rhinitis, of which they may be an important cause, when present. Records show that this abnormality is more frequent than any other trouble of the nose, but in many they produce no untoward symptoms. Of the 1000 cases above-mentioned, only about 200, or one-fifth of them, were removed. These operations are increasing, as more and more the baleful effects of spurs are being recognized. When of large size they seriously interfere with respiration and may lead to trouble in the accessory sinuses of the nose. It is easy to see how a spur high up on septum could press against the middle turbinal body, which in turn presses against the hiatus of the antrum of Highmore, causing the secretions to be retained, which later are apt to set up an empyema.

* Reports of Presbyterian Eye, Ear and Throat Charity Hospital, Baltimore.

The impaired respiration causes serious trouble in the ventilation of the tympanic cavity through the eustachian tubes, which if not attended to would lead on to permanent hopeless deafness. A pharyngitis and a naso-pharyngitis is set up on slight provocation, and later they take on a chronic condition. The mouth-breathing sets up a laryngitis with a train of pulmonary trouble possible. The patient complains of "cough," "hawking," and "spitting." The mucous discharge being blocked up from the front follows the course of least resistance down the naso-pharynx, with the feeling of something dropping into the throat so often complained of. The voice has a "nasal twang," so distasteful to public speakers and singers. Nasal asthma, paroxysmal sneezing, and hay fever are influenced if not caused by them.

Several diseases of the eye are in some way connected with spurs of the nasal septum, as well as other troubles of the nose. Severe cases of conjunctivitis, keratitis, corneal ulcer and lacrymal troubles have been improved if not cured by their removal. Wright, of Brooklyn, gives a list of neuroses occasionally ascribed to lesions in the nasal cavities which may well be mentioned here. They are "esophageal spasm, hiccough, spasmodic croup, aphonia, asthenopia, strabismus, blepharospasm, migraine, chorea, epilepsy, vertigo, aprosexia, dyspepsia, exophthalmic goitre, acne, erythema of the skin, neurasthenia and melancholia." How these effects are produced through the nose or septal spurs (the most common trouble) it is not known. However, it is true that the nose is a wheel *with many cogs* in a complicated and mysterious mechanism. Therefore, how essential it is that the physician should keep a watchful eye over this part of the human anatomy for any abnormalities, and treat them with the hope of alleviating some trouble that can not be accounted for in any other way.

The indications for operation on septal spurs may be summed up as follows:

1. When the spur is large and materially interferes with respiration, especially when nasal symptoms are present.
2. When the patient has a pharyngitis or a naso-pharyngitis which does not yield to local applications. When they complain of "hawk-

ing" and "spitting" and a husky voice with always a desire to clear the throat before speaking.

3. Eye troubles of the nature mentioned above that do not respond to treatment readily should be given the benefit of an increased air space in the nasal cavities.

4. In cases of ear troubles with impaired hearing.

5. Any condition, neurotic or otherwise, which does not improve under treatment and in which a septal spur exists should receive the benefit of the doubt and the spur should be removed. Great good may be derived from the increased air space and rarely, if ever, any material harm follows the operation, especially if the after treatment is thoroughly and carefully conducted.

Depending upon the location and the size of the tumor, this operation is at the same time one of the easiest or one of the most difficult. It may be accomplished by either the open or the sub-mucous method. In the former the spur is removed without any attempt to save the mucous membrane. In the latter an incision is made in the mucous membrane over the tumor. With a small raspatory the membrane is raised over the spur, which is then removed, and the mucous membrane is then placed in position against the septum and held there by a slight packing. This is an ideal method, requiring considerable patience and ingenuity on the part of the surgeon. If successful it leaves the tissues intact and the septum will be smooth. There is a tendency for the mucous membrane thus treated to fail to unite with the septum, to form loose, hanging pieces of tissue with synchias, or to slough out entirely, and then we have the opened method above referred to. The sub-mucous method is possible only in selected cases.

The operation under cocaine hydrochlorate (4 per cent to 10 per cent) can be accomplished easily by most physicians after a little practice. To the patient it is not very painful. It is true they feel it, but it does not hurt much. The operator's saw may touch the sides of the choanæ or the sensitive naso-pharynx and so produce considerable uneasiness on the part of the patient, requiring the head to be steadied by an assistant. Otherwise the surgeon can do the operation alone.

For instruments he will want a small nasal saw, a pair of nasal scissors, a speculum, forceps, and applicators. Other instruments sometimes used are Hajek's chisels, Krause-Schortz double chisel, and the trephine. The chisels and mallet enable the operator to work quickly before the effect of the cocaine wears off. The double chisel can be used only in selected cases when the spurs are small.

The operation may be almost bloodless by the use of extract suprarenal capsules. The writer finds that the following method of its preparation is the most satisfactory, as it gives a clear solution (reddish-brown) which does not deteriorate with age. For a $\bar{3}$ iii solution—

R	
Ext. suprarenal capsules (desiccated gland),	$\bar{3}$ ii
Chloretone saturated solution (about 1%),	$\bar{3}$ iii

Mix and let boil over a water-bath for an hour, tightly cork and let stand for twenty-four hours. Then carefully filter, adding more of the chloretone solution until a $\bar{3}$ iii solution of suprarenal capsules is obtained. This gives an aseptic solution ready for use, not only in nose surgery, but also in the eye and ear, but to a less degree.*

This solution may be applied with a mop or spray in the same manner as the cocaine, alternating with it, or a small wad of cotton soaked in the solution may be inserted in the nares alongside of the spur.

When the spur has been removed orthoform powder blown on the raw surfaces will relieve much of the after-pain. At the time of operation small spurs and those showing no signs of hemorrhage need no further dressing except a piece of cotton in the vestibule during cold weather while patient is going home, to be removed on arrival. In other cases the nares will have to be packed with gauze and this is accomplished easily for the operator and almost painless for the patient with the aid of a No. 1 Nasal Packer, which works well only when the plunger has three prongs which come out even with the end of the pipe for carrying the gauze.

As the gauze gives a great deal of discomfort, leading to mouth-

* Since the above went to press I have found that a gr. x— $\bar{3}$ i solution made up in the same manner is also efficacious and cheaper.

breathing, it is well to remove it the next day and not repack unless it is indicated by persistent hemorrhage. Though the gauze is removed so early it is necessary for the physician to impress upon the patient the necessity of after-treatment to prevent ulceration, granulation or synechia. The importance of frequent visits for this purpose can not be too highly estimated.

The mucous membrane will gradually grow over the denuded surface. The patient will be troubled for a time with scabs in the nose. Should there be any roughness or projections over the healing tissues these may be snipped off with the snare or nasal scissors, and in the end your efforts are crowned with a smooth septum. This is generally followed by a rapid improvement in the patient's condition. He breathes more freely, and his former throat difficulties give him no more trouble.

SKIN-GRAFTING.

By JOHN B. McMURRAY, '01.

Skin-grafting is the application of minute pieces, or strips, of epidermis to a granulating surface for the purpose of hastening cicatrization and diminishing subsequent contraction.

The principle being if a piece of living, active epidermis be transferred to proper soil it will grow there and serve as a focus for cicatrization; will unite with similar points or with the cicatrizing edges of the ulcer or denuded surface, thus closing it more rapidly, diminish the natural tendency to contraction and prevent the formation of a weak scar; also stimulating the edges of the wound to proliferate epidermic cells more rapidly.

Skin-grafting is applicable to any simple, healthy, healing ulcer. This form of ulcer has edges that are smooth and shelving, and extend in the form of a bluish-white film over the marginal granulations. The base is level, or nearly so, and covered with healthy granulations. Healthy granulations are not exuberant or pulpy, but are firm and a light pink in color. The discharge is inodorous pus, or, if the ulcer is dressed antiseptically and all irritation avoided, merely healthy serum. The surrounding skin is healthy. This is the type

that all ulcers assume when healing. In this form of ulcer all that is necessary to bring about perfect results is rest and protection from irritation and infection. If large, skin-grafting is applicable and the best of results are hoped for if the technique *be* perfect. All ulcers do not, however, conform to this simple type. They may be covered with fungus or exuberant granulations, when the venous return is impeded, as in burns; or oedematous and weak, healing for a while, and then ulcerating again, as in tuberculous ulcers, or as the result of the too protracted use of emollient applications. Some are inflammatory, as in chronic alcoholics, or inflamed as the result of irritation to an otherwise healthy ulcer. It is obvious that grafts would not be most satisfactory on these forms; therefore, it is necessary that all ulcers must be treated by methods most suitable for each that they may be converted into the simple form before any attempt be made. Phagedenic, sloughing, varicose and eczematous ulcers belong in the same class, but require surgical treatment.

While the term ulcer is, strictly speaking, an open sore produced by a loss of substance of the free surface of the skin or mucous membrane in the process of ulceration or of ulceration and gangrene combined, it is also sometimes extended to any open granulating wound, the result of an injury or an operation. Skin-grafting is applicable to ulcers in the broadest meaning of the term when they conform to the simple type.

Reverdin, an interne in La Charité Hospital at Paris, was the first to do any work of this kind. Hamilton claims priority, however, but his own report of the operation was under the head of "Elkoplasy, or Ulcers Treated by Anaplasty," it being a form of interpolation with a pedicle. The ulcer he treated was situated on the left leg of a negro. He covered it with a flap from the right leg, leaving it connected by a pedicle until it had become sufficiently attached to the floor of the ulcer that its nutrition would not be seriously interfered with when the pedicle was cut. This, although a form of plastic surgery, was not strictly skin-grafting. Reverdin, in reporting his method, called it "epidermic grafting." The European surgeons became interested in the subject and gave him opportunities for experiments. Poncet of Lyons, and Pollock of London, soon practiced the operation and reported success.

The operation as used to-day is done under thorough anti- and asepsis. The surface of ulcer is cleaned thoroughly, and all the antiseptic solutions used completely removed by the free use of hot,

sterile normal salt solution. All bleeding occasioned by the cleaning is checked by pressure and the hot solutions. While the surface from which the grafts are to be taken is being prepared, keep the surface of the ulcer moist with the salt solution. The site from which the grafts are to be taken must be shaved and rendered aseptic, a part being chosen with few glands, and the skin not thick as on the side of the chest below the axilla, inner surface of the thigh, or flexure of the elbow. Many instruments have been devised for obtaining the graft, but a needle and a small pair of scissors, or a pair of iridectomy forceps and scissors answer all purposes.

The skin is grasped with the forceps or elevated with the needle and clipped off with scissors. The pieces should be about the size of a pin's head and thick enough to include the deeper, active layers of the epidermis. These points should be deposited at once on the ulcer, cut surface down, being careful to avoid pressure. They should be placed one-quarter of an inch from the edge of the ulcer, and about that distance from one another. It is very important that the grafts should extend around the edge of the ulcer, the others being laid parallel with them, unless the edge be irregular, when the number of grafts placed can be reduced by laying bridges from one irregularity to the other.

If the surface to be covered is large, a second operation may be necessary, for those grafts nearest the edge begin to grow more rapidly as they become connected with the cutaneous circulation. Those next to the ones already proliferating take on activity and so on until all are growing. Those most centrally placed will become devitalized before sufficiently nourished to grow. Each separate island of epidermis does not grow indefinitely from a given center, but only over an area of about one-quarter of an inch in diameter; thus the necessity of placing them so close together.

After the operation has been completed, cover with narrow strips of protective; over this a moist dressing. A piece of oiled silk should be put over this to retain the moisture. Cover with cotton and retain with a lightly applied bandage. Remove all but the lattice-work of protective in three days; irrigate and re-dress as before. At the end of the first week remove all dressing and irrigate with salt solution, at which time the superficial layers of the grafts will be washed away, appearing to the inexperienced as if the operation was a failure. Re-dress, and by the next dressing bluish-gray lines radiating from many points will be indicative of success.

Unfortunately, two of the objects of skin-grafting are not obtained by this method, *i. e.*, diminished subsequent contraction and a resistant scar.

Thierch, in studying the cause for Reverdin's method, not being successful, found it due

1st. To a misunderstanding of the natural healing process of ulcers.

2d. The grafts used were too small. Each graft being a center of growth, the points where the epidermal cells united with those derived from other centers of proliferation, left weak points in the cicatrix, non-resisting and prone to separate.

He introduced a new and more favorite method, named after himself, based upon the following observations:

1st. That the healing of any surface consists in a conversion of the soft vascular granulations by contraction of some of their elements into young connective-tissue cells—into dry cicatricial papillæ, thus actually approximating the surrounding tissues, diminishing the area to be covered by epidermis.

2d. That the new tissue is covered by epidermic cells.

3rd. That the vascular supply is arranged in two sets, a horizontal network at the base of the vascular granulations, and a vertically arranged set extending up into the granulations.

The conversion of the vascular granulations into dry cicatricial papillæ is limited in large healing surfaces, owing to the natural laxity of the tissue being reached.

If grafts are placed over this non-contracted vascular area, any irritation will cause the pulpy tissue to discharge a serous fluid, raise the epithelial covering and cause it to separate or slough off. If it does not separate, the presence of the epidermal covering will stimulate the new tissue underneath to contract, either one of the results defeating the purpose of the operation.

Thierch consequently recommended that all the soft vascular granulations be scraped off until the horizontally placed network of vessels be reached, and place long, wide strips of epidermis over the floor of the ulcer.

After removing the granulations it is advised to pare the edges of the ulcer to get rid of any epithelium already formed, as at this point the scar is found to be the weakest. Render the surface to be grafted thoroughly aseptic, but do not allow any of the antiseptics to remain on the field, as the life of the grafts are endangered by the

weakest antiseptics. All bleeding must be controlled, as the grafts may be prevented from "taking" by the intervention of a blood-clot. Pressure is most efficient, first placing a piece of smooth protective over the bleeding surface to avoid exciting hæmorrhage by the removal of rough gauze.

The method of obtaining the grafts is simple: a broad, sharp razor, or microtome knife, is grasped in one hand, the skin being held tight by an assistant, and by a steady to-and-fro movement thin, long, wide strips are cut and floated back on the knife by a continuous stream of salt solution and floated off in a similar manner, being placed by the assistance of a probe or needles devised for the purpose. The whole surface should be covered, each section overlapping the other, the first overlapping the edge of the ulcer or denuded surface.

The part chosen from which the grafts are to be obtained is largely a matter of choice, but should have little subcutaneous fat. Three sources are utilized:

I. Zoo-grafting, or grafts obtained from animals. Many animals have been used for this purpose.

Rodgers, U. S. N., after the suggestion of Redard, grafted a patch 6-8 inches over the buttocks of a man 38 years old from the under surface of a fowl's wing with success.

Vanmeter used the skin off two young puppies of the Mexican hairless breed, with all the success desired, on the arms and legs of a young man. The same time he used grafts on the patient's face taken from the man's father and brother, which did not do so well.

Masterman used the inner membrane of a hen's egg. A Mexican surgeon, Altramirano, used the gills of a rooster; Fowler, of Brooklyn, the back and abdomen of frogs over 247.95 square inches of burnt surface.

II. Hetero-epidermic method: grafts obtained from other individuals. It is important that the donor be young and free from disease. Deubel reports one case of a father becoming infected with syphilis by grafts taken from his son.

Fowler grafted white epidermis on a colored man. The scar was pigmented to its normal degree after some months. Martin and others have used grafts taken from amputated limbs and warmly recommends its use in large hospitals where amputations and grafting occur on the same day. He further asserts that amputated limbs are capable of furnishing active grafts for many days if kept below 32° F., but soon lose their vitality if the temperature rise above 82° F.

J. H. Girdner applied to the arm of a boy badly burned by electricity, grafts taken from the body of a young man who died from hæmorrhage. In one case he used grafts from the body of a man 70 years for a boy 17.

III. Auto-epidermic method, or taking the grafts from the same person. This is possibly safer in all cases than the latter, but is not always applicable. Corns and warts have been used but are uncertain.

After the grafts have been placed, put protective tissue over the entire surface and cover with a thick, moist dressing, as in the method described for Reverdin's operation. Mayer has recommended the use of two gauze collars, one above and one below the wound, and sterile sticks placed across them. The moist dressings are placed on these, thus avoiding all pressure. Place warm water bottles around the part, and moisten the dressings twice daily. Irrigation is necessary after the third day, at which time cover with borate albolene ointment.

Krause has revived the old method of skin-transplantation. The entire thickness of the skin is used, cutting the flap one-third larger than the surface to be covered. Maintain the graft in position by gauze moist in normal salt solution, over which place a thick dressing. Remove in four days; puncture any blebs that may have formed and re-dress.

The principles of skin-grafting are successfully applied to mucous membranes.

As mucous surfaces are difficult and in most places impossible to keep from infection, success is not so sure as on a cutaneous surface.

The grafts are taken the entire thickness of the membrane, and cut larger than the surface to be covered. The difficulty in retaining the grafts in most places is overcome by stitches, avoiding tension.

This form of grafting has been applied to the urethra, oral cavity and eye. The grafts have been taken from other mucous surfaces of the human body and the œsophagus of the pigeon and rabbit. Wolfe used the conjunctiva of the rabbit for grafts in the eye, and Stellnay the mucous membrane of the lips and vagina for the same purpose.

Wolfer utilized the mucous membrane of the rabbit's stomach and bladder in urethral stricture.

WILLIAM S. GARDNER, M. D., EDITOR,
1012 McCulloh Street,
Telephone 799 M.

WILLIAM J. TODD, M. D., BUSINESS MANAGER,
Postal Station No. 202.
Telephone, C. & P., Tuxedo, No. 303.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

ANNOUNCEMENTS.

Final examinations begin Monday, April 15, 1901.

Alumni Meeting and Banquet, Saturday, April 27th, 8 P. M.
(HOTEL LEXINGTON.)

COMMENCEMENT.

Monday, April 29th, 12 M., Ford's Grand Opera House. Orator,
Hon. Thos. G. Hayes, Mayor of Baltimore.

THE RELATION OF PELVIC LESIONS TO SOME
NEUROSES.

Much very confusing discussion goes on between the neurologists at one extreme and some gynecologists at the other as to the relation existing between pelvic lesions and some of the neuroses. The discussion often becomes heated on account of the fact that each party to the discussion is not sufficiently familiar with the field of the other's work.

The truth undoubtedly lies between the two extremes. There are many women who have nervous and mental disturbances who have no pelvic lesions; there are many women with pelvic lesions

who have no marked disturbance of their nervous systems; there are women who have both pelvic lesions and a neurosis without any relation existing between the two; but there are, without doubt, certain cases in which the neurotic condition is associated with a pelvic lesion, and which is promptly relieved by curing the disease in the pelvis.

It is conceded that a large proportion of the cases of puerperal insanity are due to infection; and that the original point of infection has been in the pelvis.

There are other neurotic symptoms that are due to some injuries to the cervix and perineum, and also to some other pelvic lesions, but they are not constant and it is not always possible to trace a definite relation between the symptoms and the lesion.

Much more common and easily demonstrated are the hysterical phenomena that are associated with acquired retrodisplacements. In these conditions the nervous symptoms are among the most constant outward manifestations; and they disappear with surprising rapidity when the displacement is corrected.

These cases present the phenomena of true hysteria—using the word in its original meaning.

W. S. G.

THE Students' Medical Society of the College of Physicians and Surgeons held their last meeting for the year in the college amphitheater, March 18, 1901.

A paper prepared by Mr. C. H. Brückner, on "Blood in Typhoid Fever, especially considering the Leucocytosis and Perforation as a Complication," was read by H. R. McGraw.

Professor William Osler was introduced to the Society, and was received with hearty and sincere applause by a large audience. Dr. Osler delivered an address on "The Powder of Sympathy."

Personal Notes.

J. FRANK RUTHERFORD, '92, has returned to Bishop, Pa.

DR. N. P. H. WHITE, '89, has removed to Geary, Oklahoma.

DR. THOMAS L. PATON, '87, is City Physician to Paterson, N. J.

DR. G. N. YAGLE, '95, has removed from Windsor, Pa., to Red Lion, Pa.

DR. J. J. MOORE, '93, has located at South Charleston, Clark County, Ohio.

DR. ARTHUR HAWKINS, '95, has removed from Mt. Savage to Cumberland, Md.

DR. J. J. MCCARTHY, '96, is in Baltimore representing the Chas. H. Phillips Chemical Co.

DR. E. A. BOWERMAN, '95, is assistant physician to the State Hospital for Insane at Buffalo, N. Y.

DR. HERBERT EMERSON, '94, is making a specialty of Diseases of Women and Children at Paterson, N. J.

DR. FRANK J. PHILLIPS, '89, passed through Baltimore recently. He had been on a trip south for his health.

DR. E. C. STEWART, '87, has charge of the Gynecological Department of St. Francis Hospital at Pittsburg, Pa.

DR. B. L. ASHBROOK, '92, of Marion, N. C., brought a patient to the City Hospital recently. He has a profitable practice.

DR. SEATON NORMAN, '81, under the recent army reorganization bill, has been appointed surgeon with the rank of major.

DR. TIREMAINE E. ARMSTRONG, '99, has succeeded to the practice of Dr. Bittle C. Keister, '82, at South Boston, Va. Dr. Keister has removed to Roanoke, where he has built a sanitarium.

DR. HARRY VAUGHAN, '95, of Morristown, N. J., writes that DR. N. H. ADSIT, '86, has an unusually large practice at Succasunna, N. J., and intends building a fine residence in the near future.

DR. J. B. PAYNE, '96, of Lumberport, W. Va., spent a part of January in Baltimore. He expressed himself as being especially pleased with the change in the College building. The Doctor has built up a good practice.

DR. J. GORSE SIMMONS, '91, ex-president of the Alumni Association, had the distinction of introducing to this world the first set of triplets born in the new century in Greater New York. There are two girls and a boy. At last report all were doing well.

DR. CHAS. B. WALDON, '93, of Saratoga, N. C., spent the last two weeks of December at the College doing special work. The Doctor has been health officer for Wilson County for the past four years, but has been obliged to resign on account of his increasing practice.

DR. DANA C. HIGHRIETER, '86, of Fulton, N. Y., died February 9, 1901, of rheumatism. He began his practice at New Haven, Oswego County, N. Y., but afterwards removed to Fulton, where he formed a partnership with Dr. N. F. Hall, '86. He was a successful practitioner and was one of the prominent physicians of the county.

PROFESSOR JOSEPH MCFARLAND, of Philadelphia, has undertaken a series of experimental researches into the etiology, pathology, toxic products and possible cures of the various infections, at the laboratory of Parke, Davis & Co., Detroit. His work will be of a purely scientific character, and as it is undertaken under such favorable conditions, it is not too much to expect that something definite will be added to our knowledge of infectious diseases.

IN the fourth biennial report of the Board of Directors of the Second Hospital for Insane, located at Spencer, W. Va., the following reference is made to the superintendent:

"It is but due to a most faithful and efficient officer, Dr. L. V. Guthrie, the superintendent, to state in this connection that the above most excellent showing of the financial condition of the institution is due mainly, if not wholly, to his untiring energy, zeal, economy and personal supervision and attention to every detail in the management of the hospital."

KEYSVILLE, VA., March 20, 1901.

EDITOR OF THE JOURNAL:—I take great interest in reading everything which appears on the pages of our ALUMNI JOURNAL from editorial to advertisements, and welcome each number as a personal letter from our boys, who, though scattered all over the world, are bound together by the strongest bonds of comradeship. I am always glad to hear of their successes and achievements, and in all matters I always want to see the P. & S. and her alumni take front rank and keep at least full abreast with the times, but in the last number I read with regret your editorial comments on the extract from the report of the Virginia State Board of Medical Examiners relative to the standing of graduates from the Virginia Medical School before the Board, and because they showed a higher standard of fitness on examination, you were disposed to suggest reasons for this which were neither just nor complimentary to the Board. Some of your comparisons were invidious; that of comparing, say the Medical Department of Harvard, which has sent down probably one or two men of very ordinary attainments, with out Virginia schools, which send the most of their graduates before this Board, numbering hundreds. Of course, the great number will give them an advantage on a general average. You say this state of affairs can only be accounted for by one of two theories—that Virginia is such a poor State, that as a field for practice the best men from schools beyond the State will not come here, or that the Board has a way of knowing the graduates of Virginia schools, and are partial in their rating for them. Now, this last theory is unworthy of you for whom I have so much admiration and such a high regard personally, and as the editor of the organ of a great and honored medical school. The Board never knows the name or Alma Mater of any of the applicants, as a number is assigned to each applicant by the secretary, Dr. R. S. Martin, who is a P. & S. graduate and an honor to the school as well as to the profession of Virginia, and all papers are signed by that number. Of the thirteen regular members of the Board, four of us are P. & S. men, who are proud of our Alma Mater, and would allow no injustice to be done her graduates. I think no other school

has so many representatives on the Board. If Virginia is a poor field for the practice of medicine, we are fortunate in having such a large number of graduates willing to enter practice every year that we can afford to select the best, and when our own State schools supply almost enough of the *best* for the demand, we naturally feel some pride in the fact. It would not surprise me if, on investigation, it were shown that the graduates of Virginia schools always take high rank before the other State Boards, the Army and Navy Boards, etc. You re-echo the sentiments expressed by the editors of the *Practice* that the State Board of Virginia should turn its back on the work done in the past, with the advent of a new century, and face a new order of things. Well, let us graduates of other schools than those of Virginia, who now live within the State, express the hope that with the new century the schools from which we have graduated beyond the borders of the State may so improve their work that their graduates will always show as high grade before the different State Boards as the graduates from the Virginia or any other schools. With best wishes for the P. & S., I am,

Truly yours,

A. S. PRIDDY, Class of '86.

DR. THORNTON W. PERKINS, '00, wrote to one of his old classmates as follows:

SOLANO, P. I., PROVINCE NEUVA VISCAYA, NORTHERN LUZON.

I have just reached my station after a long and tedious journey. Am situated about 400 miles from Manila in a very pretty part of the Island. Left Manila about the 28th of September on a steamer for Apaira, Northern Luzon. After remaining in this town for three days, set out up the Cagayan River in a steam launch as far as Tulloc. From this point we went aboard the steamer Cagayan as far as Iligan. Stayed over night at this place and left early the next morning, journeying up the river on a barongay. Well, of course you do not know what a barongay is—in fact, you would be glad to avoid one of these boats if you had to make the trip. It is a native boat about forty feet long made of bamboo and covered with grass. The

natives use long poles to steer this arrangement and travel at the rate of about one mile an hour. Just think of traveling in this cooped-up style for a little over two weeks. Notwithstanding, we found a great deal of pleasure in shooting game along the river. We killed several monkeys and quite a number of wild ducks. You would have been much amused if you could have seen us eating this monkey meat—really a delightful dish. Some of the boys shot an alligator and had a stew—I begged to be excused from this new dish. We killed a few goats, also a new dish for me. The wild hog makes a very sweet meat.

On this trip I was reminded very much of Henry M. Stanley's description of the jungles of Africa.

We had an escort of nine armed men with us on the trip. The greatest part of the trip was a 50-mile journey over the mountains on a mule. We had a pack-train with us about a mile long carrying rations over the trail. We were nearly three days in making this trip. We passed through one little town that had just been attacked by the insurgents. One of our American soldiers was killed and two wounded. Thirty-six Insurrectos were killed and quite a number wounded. The soldiers had just buried all the native dead in one big grave. From the appearance of their quarters the Insurrectos must have given our boys a warm reception.

On our trip across the mountains we came in contact with a tribe of people called Igorrotes. They appeared to be very much uncivilized but peaceful, and in some respects not unlike our North American Indians. These people had their spears and dogs hunting deer.

We slept in a house that had been abandoned by the natives who had been run out by a band of people called the "Head Hunters." I suppose there were about thirty deserted houses in this place. Of course we expected possibly they would pay us a visit.

We left this forsaken place about 5 o'clock the next morning and continued our journey across the mountains. The sensation is something delightful along these little narrow trails when one looks far below him.

Have charge of two hospitals, one at this place and one at a little town called Bogabog in the same province.

The natives over in this country are all rather an indolent class of people. They cultivate a little rice and depend upon their tobacco crop for their earnings. However, some of them do not work at all. How they manage to subsist He only, who sees into all mysteries, can tell. The subsistence of these people is a puzzle to me, yet they do subsist, and, what is more, seem to enjoy their existence.

There are two classes of people to whom life seems one long holiday: the very rich and the very poor. The former because they need do nothing; the latter because they have nothing to do. However, there are none who understand the art of doing nothing better than these natives—climate does one-half and temperament the rest. Give the Filipino a shade in summer, sun in winter, a little rice, a pony, some wine, a guitar, and let the world roll on as it pleases.

Poverty! With him it adds no disgrace. Even in his hovel he is an *hidalgo* in rags.

Yet, apparently idle all the week they are as observant of all Saints' days and holidays as the most laborious artisan. He never misses a Sunday afternoon attending cock-fights and is a "dead game sport" when he goes to the pit. He will stake his last *Dobie Dollar* (Mexican dollar) on his favorite chicken being the winner.

In listening to the conversations and observing their manners, I have picked up many curious facts illustrative of these creatures. They are exceeding polite to an "Americano" in their homes, through fear in most instances, I believe, and it is almost an indispensable point of politeness with them to tell you upon calling that his house is yours, or, as he would say in his language: "*Esta casa es siempre a la disposicion de um*"—"This house is always at the command of your grace." In fact, any thing of his which you admire is immediately offered to you; however, it is equally a mark of good breeding not to accept it.

THORNTON W. PERKINS, M. D., Surgeon, U. S. V.

HYPODERMATIC TABLETS

SOLUBLE, ACCURATE, PERMANENT.

You can always depend upon our Hypodermatic Tablets in every emergency. They contain the exact quantity of medicament indicated upon the label, and dissolve not only promptly but completely.

YOU WILL NEVER BE DISAPPOINTED IF YOU SPECIFY P., D. & CO.



In tubes
of 25 tablets.
Marketed in
handsome cartons
containing 4 tubes.

ALSO IN
BOTTLES
OF 100.

HOME OFFICES
& LABORATORIES,
DETROIT, MICH.
BRANCH LABORATORIES
HOUNSLOW, ENG.
WALKERVILLE, ONT.

PARKE, DAVIS & CO.

BRANCHES IN
NEW YORK, KANSAS
CITY, BALTIMORE,
NEW ORLEANS,
LONDON, ENG.,
& MONTREAL, QUE.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, N. Y., Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S. Ohio.
E. PARMLY BROWN, D. D. S. N. Y.
A. L. NORTHPROP, D. D. S. N. Y.
E. L. HUNTER, D. D. S. N. C.
W. W. WALKER, D. D. S. N. Y.
OSCAR ADELBERG, D. D. S. N. J.
G. MARSHALL SMITH, D. D. S. Md.
C. M. GINGRICH, D. D. S., Resident. Md.
J. HALL MOORE, D. D. S. Va.

R. B. DONALDSON, D. D. S. D. C.
H. A. PARR, D. D. S. N. Y.
J. EMORY SCOTT, D. D. S. Md.
C. L. ALEXANDER, D. D. S. N. C.
M. M. MAINE, D. D. S. Conn.
J. W. DAVID, D. D. S. Texas.
A. C. BREWER, D. D. S. Md.
J. ROACH, D. D. S. Md.

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

W. W. DUNBRACCO, D. D. S. J. K. BURGESS, D. D. S. J. C. SUTHERLAND, D. D. S.
GEO. V. MILHOLLAND, D. D. S. CHAS. THEBERATH, D. D. S.
L. M. PARSONS, D. D. S. HARRY E. KELSEY, D. D. S. C. H. CARSON, D. D. S.
H. M. LEVER, D. D. S. C. S. GORE, D. D. S. L. F. PALMER, D. D. S.
C. R. STEWART, D. D. S. L. D. CORIELL, D. D. S.
H. H. HAYDEN, M. D., Demonstrator of Anatomy.
C. F. BLAKE, M. D., Demonstrator of Anatomy.

The Sixty-First Annual Session will commence on the 1st of October, 1900, and continue until May, 1901.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD

College of Physicians and Surgeons OF BALTIMORE.

FACULTY

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- AARON FRIEDENWALD, M. D.,
Professor of Diseases of the Eye and Ear.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Pathology and Medical Jurisprudence.
- C. HAMPSON JONES, M.B., C.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, M. D.,
Professor of Obstetrics.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- W. F. SMITH, A. B., M. D.,
Associate Professor of Surgical Anatomy.
- B. HOLLY SMITH, M. D., D. D. S.,
Professor of Principles and Practice of Dental Surgery as applied to Medicine.
- HARRY FRIEDENWALD, A. B., M. D.,
Associate Professor of Diseases of the Eye and Ear.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MOOLEARY, M. D.,
Associate Professor of Physiology and Demonstrator of Histology and Pathology.
- CHARLES E. BRACK, M. D.,
Associate Professor of Obstetrics and Lecturer on Pharmacy.
- JOHN RUHRÄH, M. D.,
Associate Professor of Diseases of Children and Demonstrator of Pathology.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy and Demonstrator of Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Assistant Demonstrator of Anatomy.
- SYLVAN H. LIKES, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MOGLANNAN, M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- ALBERTUS COTTON, M. D.,
Demonstrator of Surgery and Assistant Demonstrator of Anatomy.
- GLENN M. LITSINGER, M. D.,
Demonstrator of Obstetrics.
- M. EKSTRÖMER, M. D.,
Demonstrator of Chemistry.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- SYLVAN ROSENHEIM, M. D.,
Demonstrator of Bacteriology.
- ARCHIBALD C. HARRISON, M. D.,
Assistant Demonstrator of Anatomy.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Clinical Assistant in Gynecology.
- W. B. WOLF, M. D.,
Demonstrator in Clinical Laboratory.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- S. S. HOULTON, M. D.,
Assistant in Diseases of Stomach.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Issued Quarterly

Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS
BALTIMORE.

Vol. IV

No. 2

JULY, 1901

PUBLISHED AT
Baltimore and Eutaw Sts. Baltimore, Md.

GIVES BEST RESULTS

MULFORD'S ANTITOXIN

PHILADELPHIA, CHICAGO:

H.K.MULFORD
COMPANY
CHEMISTS

Mulford's Glycerinized Vaccine

is prepared with every possible aseptic precaution. Each separate yield is subjected to the most rigid tests. It is guaranteed to succeed in 100 per cent. of primary cases, and retains its activity at least six months.

The virus from absolutely healthy animals only is employed, and each separate yield is subjected to the most rigid Physiologic and Bacteriologic tests.

H. K. MULFORD CO.

Chemists

PHILADELPHIA

CHICAGO

Case of 10 tubes—10
vaccinations—\$1.00.
Mailed upon receipt
of price. Write for
literature.

The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,

CATONSVILLE, Md.

REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
Removal of the Crystalline Lens for High Degrees of Myopia. DR. AARON FRIEDEN- WALD,	33
On the Treatment of Tetanus, with Report of a Case that Recovered under Sympto- matic Treatment Alone. DR. THOMAS R. BROWN,	35
Bacteriological Diagnosis of Typhoid Fever from a Clinical Standpoint. DR. J. HALL PLEASANTS,	43
The Blood in Typhoid Fever, Especially Considering the Leucocytes, and Perforation as a Complication. CHARLES H. BRUECKNER,	48
The Diagnosis of Gonorrhœal Prostatitis. DR. W. B. WOLF,	54
Editorial,	57
Personal Notes,	iv, 60
Correspondence,	62

**"OUR
LEADER."**

Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.

All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,
 BENJ. A. NELSON, General Manager,
MANUFACTURERS AND IMPORTERS,
300 N. HOWARD STREET, - - - BALTIMORE, MD
 PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES.

ST. AGNES' SANITARIUM.



This Institution is beautifully situated on high, rolling ground, just outside Baltimore, and overlooking the Bay. It is thoroughly equipped as a modern Sanitarium for the treatment of Nervous Diseases and Drug Habits (no mental cases received). A complete Hydrotherapeutic Establishment has been recently added. Electric outfit, Gymnasium, Massage by trained operators, Sun Parlors, Billiard Rooms, Tennis, Golf, &c.

Medical Director, George J. Preston, M. D., Professor of Nervous Diseases, College of Physicians and Surgeons, Baltimore.

For further information, terms, &c., address

THE SISTER SUPERIOR,

St. Agnes' Sanitarium, Carroll P. O., Baltimore, Md.

Personal Notes.

DR. ALBERT HARE, '83, died recently at the home of his sister in Tarentum, Pa.

DR. CHAS. F. MOHR, '91, has removed from New York City to Providence, R. I.

A CARD.

At the beginning of another season, we beg physicians to consider the advisability of sending more of their patients to us for prescriptions and sick-room supplies. We will waive matters of ethics and base our claims for additional patronage upon the excellent character of our work, the better results secured through concentrated efforts and upon the advantages a comprehensive stock gives us.

MICROSCOPICAL AND
CLINICAL SUPPLIES.

HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

IN CYSTITIS

and all inflammatory conditions of the urinary tract, difficult and painful micturition, wetting of the bed and wherever a demulcent diuretic is indicated

LITHIATED SORGHUM COMP. IS AN INFALLIBLE REMEDY

as the testimony of thousands of physicians bears evidence. It has acted in many instances where other remedies have failed to alleviate the condition of the patient or cure the disease. It possesses a pleasant, palatable taste and produces no cumulative or other undesirable effects. Its value depends upon the formula

AND CONTAINS

R	Broomcorn Seed (<i>Sorghum Saccharatum</i>)	}	120 grains.
	Corn Silk		
	Saw Palmetto		
	Hydrangea		
	Lithium Benzo-Citrate		16 grains.
	in each fluid ounce.		

Literature and Samples gladly furnished on application.

SHARP & DOHME LABORATORIES,

BALTIMORE, MD.

General Offices, 41 John Street, New York, N. Y.

Western Branch, 221 Randolph Street, Chicago, Ill.

Southern Branch, 422 Gravier Street, New Orleans, La.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap has been used exclusively in this baby's bath from birth, and her perfect skin and luxuriant hair excite wonderful interest and admiration.

AS A NUTRIENT SOAP
FOR THE SKIN

Resinol Soap

IS WITHOUT A
PARALLEL.

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.,
SYDNEY, N. S. W.
Agents for Australasia.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

REMOVAL OF THE CRYSTALLINE LENS FOR HIGH
DEGREES OF MYOPIA.

By DR. AARON FRIEDENWALD.

The dangers of high degrees of myopia are well known. The progressive character may occur in moderate degrees of myopia, but it is almost certain not to spare eyes in which high degrees appear in early life.

Furthermore, it is a matter of very common experience in many cases in which the degree of myopia is very high, that concave glasses afford no satisfactory correction, and even the strongest glasses give a degree of vision far below the normal. Unfortunately, most persons so afflicted cannot wear these glasses which give them the best possible vision because of the great discomfort, or even actual pain, which they produce. They must often be satisfied to wear weaker concave glasses with corresponding diminution of vision. Thus their distant vision remains ill-defined, but this is not the only inconvenience: for the use of the eyes in close work entails a maximum degree of convergence, an important factor favoring the progressive character of the condition. Besides this, such patients are obliged to hold reading matter and other objects upon which vision is directed for near work inconveniently near to the eyes; this becomes such a tax

upon the convergence as to cause pain in the eye and headache. These patients are, therefore, often compelled to give up their work from time to time in order to obtain temporary relief.

In order to relieve the condition of high myopia and many of the dangers and inconveniences which it entails, the removal of the crystalline lens has been resorted to in recent years. The removal of the lens for this purpose is effected by discission, that is, rupture of the anterior capsule with a minute knife or needle. This operation in young persons is comparatively free from danger. It is readily seen that the removal of the lens reduces the refractive power of the eye. The amount of reduction varies with the degree of myopia, thus myopia of 20 diopters is often converted into a condition approximating normal refraction or emetropia. More important, however, even than this is the great improvement in the acuity of vision which is often gained thereby; why this occurs is not so obvious.

The operation was introduced in Germany and is now chiefly practiced in that country and on the continent in general. In America the number of cases hitherto reported is not large. The following will, therefore, be of interest:

Case 1. Louis S., aged 9, was first examined December 15, 1897. The eyeballs were fairly normal, the right eye had vision equals 6/18 with -7.0 Ds -1.0 Dc Ax. 90. The vision of the left eye was 6/18, 6/12 ptly with -8.0 Ds. On February 16, 1898, the lens of the right eye was discised with the Knapp knife. No reaction followed. The lens did not cloud up at all. On March 3, 1898, the operation was completed with a spear-shaped discission needle. On the second day following, the lens had swollen greatly and was filling up a great part of the anterior chamber. Absorption followed rapidly. The eyeball never showed any signs of inflammation. The pupil was kept dilated with atropin. During the summer the lens substance disappeared entirely. On August 16 vision of the right eye with $/7$ Ds 6/12 with $/12$ reads finest print with ease. In this case the removal of the lens produced a change of refractive power equaled to about 14 diopters.

Case 2. Goldie G. has been under treatment for a number of

years on account of a very high degree of myopia. Strong concave glasses could not be tolerated. Vision of the right eye —9 Ds 6/24. Vision left eye —15 Ds 6/24. Cylindrical glasses did not improve. I determined to operate on the left eye. The operation was performed at the end of October, 1900. The lens substance swelled up rapidly and filled up the anterior chamber, but the eye did not become inflamed nor did the tension ever rise. Absorption made rapid progress. On January 3, 1901, nine weeks after the operation, patient could see 6/18 almost with /4.5 Ds. On February 1, 1901, with /4.5 /1.0 Dc ax 105 6/12 almost. In this case the removal of the lens changed the refraction of the eye almost 20 diopters and improved the vision from 6/24 to almost 6/12 or almost double.

ON THE TREATMENT OF TETANUS, WITH REPORT OF A CASE THAT RECOVERED UNDER SYMPTOMATIC TREATMENT ALONE.

By DR. THOMAS R. BROWN.

The subject of tetanus has been so much discussed during the past few years, and so many modes of treatment have been recommended, that any communication which adds in any way to our stock of knowledge in regard to this disease should be chronicled so that it may add its little to the store, in the hope that in time a sufficient number of cases, treated in various ways, will have been collected to furnish us really reliable data upon which to base our treatment and to lessen somewhat the mortality record of this dread disease.

The case I wish to report is an instructive one in several ways; first, in its clinical history; second, in the therapeutics employed; third, in its bacteriological findings and the results of the experiments performed upon animals, and fourth, in the fact that it had a happy issue.

The patient, George Dutton, a little negro boy of six, was first seen on the twenty-third day of October, 1897, and gave a history of great interest. Three weeks before being seen, he had burned his hands severely with sulphuric acid while playing in the dirt at

Havre de Grace, Maryland; his hands were dressed with glycerine compresses.

Four days later he fell out the door, while playing in the kitchen, and had a severe convulsion, followed shortly by another, since which time to the time we first saw him, the convulsions had been very frequent.

The account of the convulsion, as given by his mother, was most interesting; first he would cry out "hold my head and press on my stomach!" then he would fall backwards, stiff as a ramrod; there were no tonic or clonic movements of the limbs, but it was impossible to bend them; and he could be easily carried by the head and feet without bending the body.

The convulsions usually lasted ten minutes, after which he would be quite himself again, always, however, asking his mother to walk him up and down the room after an attack and having a voracious appetite immediately after the attack was over.

There had been very frequent attacks of gastric pain but no vomiting, and these pains would come and go without any apparent reason.

The attacks at first were almost constant, but when first seen by us, they were less frequent and associated with less pain in the epigastrium.

He had but little appetite on the days preceding the onset of the convulsions, but since their establishment the appetite had been voracious; the bowels were constipated for the first three days, but were regular thereafter, while the micturition had always been normal. For awhile he could hardly open his jaws and it was very difficult to feed him, but this condition had improved considerably.

When first examined by us, besides the convulsions, which were more severe and more frequent at night, his chief complaints were attacks of excruciating gastric pain, inability to walk, soreness of the eyes, inability to open them widely, photophobia, granulating areas on several of his fingers, and marked contraction of the affected digits, following the burn, which had been the primary cause of his trouble.

The examination showed that the patient was rigid but was suf-

fering little pain; the heart and lungs were negative and the jaws quite markedly contracted. During the first night under our observation, he had eight convulsions, each one initiated by a sudden flash of pain across the face, a tightening of the jaws and a cry "hold my stomach!" The abdominal muscles then became board-like, the arms and legs stiff, with the former held at an acute angle with the body, and this position was assumed for from one to three minutes, after which the patient rapidly became relaxed. The attack was followed by a diffuse sweating of the head and a marked desire for food. Any sudden noise or touch would bring on an attack. The patient was given $\frac{1}{4}$ grain morphine sulphate hypodermically every four hours, while 20 grains of potassium bromide, 1 egg and 4 ounces of peptonized milk were given by rectum every four hours. Practically no feeding by mouth was attempted for the first few days, after which it was gradually returned to, while *pari passu* the rectal feeding was gradually discontinued. The bowels were kept open with calomel and salts. The patient was kept in a quiet dark room and saw only the doctor and nurse.

The improvement was steady, so that by November 3 he averaged only one convulsion a day, and towards the middle of the month they disappeared entirely; towards the end the attacks became much shorter and much less severe.

The temperature was practically normal during the course of the disease; the pulse varied between 100 and 120 the first week, after which it varied between 90 and 100. The leucocytes on October 23 were 14,300. After the convulsions ceased, the patient rapidly regained the use of his muscles, and by the early part of December was kept busy performing buck-dances and other Ethiopian specialties for the edification of the other convalescents.

On October 23, scrapings from the granulating wounds of the fingers were examined microscopically and numerous typical tetanus bacilli were found, these observations being confirmed by the late Dr. Livingood, then Associate in Pathology at the Johns Hopkins Hospital. Cultures were made on glucose agar anaërobically in a Buchner jar, with negative results, however. An emulsion of the granulations was injected on this same day into a guinea-pig's peri-

toneal cavity with the result that it died with typical convulsions in twenty-four hours' time.

On October 29 a second emulsion of the granulations from the finger wounds was injected into an animal, a white rat being used this time. The result, however, this time was negative.

The subject of tetanus has been much discussed during the past few years, mainly in connection with the development of the idea of the antitoxin treatment of disease. There were so many resemblances between the modes of action of the bacilli of tetanus and diphtheria, that the ever-increasing success of antitoxin in the treatment of the latter disease, led most bacteriologists and clinicians to expect great results with the corresponding treatment of the former disease.

Animal experiments seemed to bear out this idea; from animals after repeated inoculations, a very potent antitoxin was obtainable, which acted both protectively and curatively upon animals experimentally infected.

Unfortunately, however, in the cases of tetanus-infection in human beings, the patient is usually saturated with the toxin before the symptoms are manifest, and this mode of treatment, as we shall see subsequently, has been singularly discouraging.

Perhaps before briefly reviewing the results of this mode of treatment, it will be well to call attention to some of the recent ideas held regarding the poison formed by the tetanus bacillus and its effect upon the organism. Madsen (*Zeitschr. für Hyg. u. Infektionskrankh.*, 1899, xxxii, 2) calls attention to the fact that, besides the tetanospasmin, another toxin, tetanolysin, is formed by the tetanus bacillus, for which a special antitoxin, antilysin, is required. The tetananolysin enters into combination with the red blood-corpuscles which, after a certain length of time dependent upon the quantity of poison and the temperature, are dissolved. Miyamoto (*Deutsche med. Wochenschr.*, 1900, xxvi, 30) states that Ehrlich first showed that in the tetanus poison there were two distinct kinds of poison, one which caused the typical convulsions, and called by him, therefore, tetanospasmin, the other possessing the property of dissolving and destroying the red blood-corpuscles, at least *in vitro*, and called tetanolysin.

Jonkowsky (*Annales de l'Inst., Pasteur*, 1900, xiv, 7) gives the results of his experiments upon the effects of the tetanus poison upon the central nervous system. He found changes in the nerve cells of the spinal cord and, to a certain extent, of the brain, affecting both chromatophilic and nuclear substance, yet not pathognomonic for tetanus poisoning. In cases of severe chronic tetanus these changes were found to affect especially the anterior group of cells in the anterior horns and about the central canal, where a heaping up of mononuclear wandering cells took place. Jonkowsky regards this phenomenon as the expression of the mononuclear phagocytosis of the nervous tissue, brought about by the action of the toxin.

Before taking up the subject of the treatment of the disease, it will perhaps be interesting to mention Thalmann's (*Zeitschr. für Hyg. u. Infektionskrankh.*, 1900, xxxii, 3) views regarding the etiology of this disease. From his observations and experiments at Leipzig, he concludes, 1st, that in guinea-pigs the intact mucous membrane of the gastro-intestinal and urinary tracts furnishes no means of entrance to the tetanus bacillus; 2d, wounds of the nose furnish, either directly or by inspiration of infected air, very favorable conditions for the tetanus bacillus, while if the organs of respiration are healthy there is no danger; 3d, the introduction of spores into external wounds leads to cases of chronic tetanus, without convulsions but usually with fatal termination; 4th, in cases of idiopathic tetanus, the portal of entry is to be sought for in the mouth and nose.

As, however, has been stated several times before, the main interest in this disease is centered about the proper treatment to be employed. The modes of treatment especially under discussion are (1) the purely symptomatic; (2) the use of antitoxin administered either by subcutaneous, intravenous, intraspinal or intracerebral injection; (3) the use of emulsion of brain or spinal cord, hypodermically injected, and (4) the use of injections of carbolic acid and other substances designed to neutralize or destroy the toxin.

The purely symptomatic treatment, *i. e.*, the use of large doses of various depressants and hypnotics, as morphia, the bromides, chloral, chloroform, etc., is obviously only to be used in case no rational mode

of treatment is forthcoming. Its effect of course is to so depress the excited spinal and cerebral centers that they will react much less violently to stimuli.

The antitoxin treatment is the one about which most of the work of interest has centered, because of the hope that a rational line of therapy might be forthcoming along these lines.

Behring (*Therapie der Gegenwart*, 1900, March) recommends the use of 100 units (10 ccm.) of his serum, the dose to be repeated on the next day. He thinks the subcutaneous method of injection is quite as reliable as the intravenous and much less dangerous. He also lays great stress upon the application of the antitoxin serum to the infected wound. In another communication (*Deutsch. med. Wochenschr.*, 1900, xxvi, 2) he insists that the serum treatment to offer any chance of success must be inaugurated within 30 hours of the appearance of the first symptoms of tetanus. He concludes that if this method were followed out, which of course would require the maintenance of the serum in stock by all druggists, the mortality in man would be but from 15 to 25 per cent.

Torök (*Zeitschr. f. Heilkunde*, 1900, xxi, 36), from the results obtained by an exhaustive series of experiments upon mice, rabbits and guinea-pigs, comes to the conclusions "that the only possible hope in the treatment of tetanus lies in antitoxin treatment and in the preparation of an antitoxin of greatly increased potency, as well as one that is able to be preserved without having its strength impaired. The earlier one uses the antitoxin, the more likely is a cure to be obtained; also it is essential that large doses be given. In severe cases intraspinal and intracerebral injections must also be employed, as the quick immunizing action of the antitoxin upon the nerve cells unaffected by the poison can be definitely shown by experiment."

Unfortunately, the practical results of the use of antitoxin in tetanus in man do not harmonize with the conclusions reached by Torök from animal experimentation.

Steuer (*Centralblatt für d. Grenzgeb. d. Med. u. Chir.* 1900, iii, 5-11), in a careful resumé of the results obtained by subcutaneous and

intravenous injections of tetanus antitoxin, concludes that its use in cases with well-marked symptoms is attended with no results, even if the injection be given within 30 hours of the first manifestations of the disease, while it has also little or no effect upon the appearance of new symptoms. He comes to these conclusions from theoretical considerations, from the results of most of the experiments performed upon animals and from a statistical study of the results of serum-therapy in tetanus both in man and other animals. He of course admits the immunizing power of the serum in those cases either exposed to infection or when an infection has just started, although, unfortunately, this is of but little practical value, as in the vast majority of cases tetanus is absolutely unsuspected until the appearance of the first symptoms, *i. e.*, until the patient is thoroughly saturated with the poison.

In another communication (*Centralblatt für d. Grenzgeb. d. Med. u. Chir.*, 1900, iii, 16) the same author opposes vigorously the use of intracerebral and subdural injections of the serum, as he thinks they offer absolutely no advantages over the subcutaneous method in marked cases or as a prophylactic measure, while attended with considerable danger.

This is borne out by the series collected by Lambert (*Medical News*, 1900, July 7) in which of 52 cases treated by intracerebral injections, 33, or 63.46 per cent, died, while of the 24 acute cases treated by this method, 21, or 87.5 per cent, died.

Toeper and Oppenheim (*Arch. gén. de Med.*, 1900, iii, 4) came to the same conclusions from their study of 144 cases, 5 of their own and the others collected from the literature, of subcutaneous injection, 59 cases treated by intracerebral injection, and 11 cases by intravenous injection; from a careful consideration of all these cases these two authors conclude that the intracerebral injection gives distinctly less favorable results than the other methods, and that the subcutaneous method is the one which offers most chance of success.

Schultze (*Mittheil. a. d. Grenzgeb. d. Med. u. Chir.*, 1899, v, 1, p. 169) thinks that of the two methods, intracerebral or intraspinal, the latter is to be preferred, as it is less dangerous and as it also reaches more directly the cells especially affected.

Too few cases treated by subcutaneous injections of emulsion of brain substance, according to Wassermann's idea of "Seitenketten-Immunität," have been reported to give us any definite idea regarding their value, but Krokiewicz (Wien. klin. Wochenschr., 1899, xii, 28, and 1900, xiii, 32) reports 10 cases so treated, with 8 recoveries, while Zupnik (Prag. med. Wochenschr., 1899, xxiv, 24, 25) and Baginsky (Ther. d. Gegenw., 1900, 6) each reports a fatal case so treated, and Mori and Salvolini (Suppl. al Policlin., 1900, vi, 30) a case that was cured; all, however, agreeing that the treatment had a considerable effect upon the symptoms, causing them to diminish in a marked degree.

The method of Baccelli, *i. e.*, the subcutaneous injection of carbolic acid, has been used but little, a few of the Italians occasionally reporting isolated cases so treated.

Perricone and Tapuppo, and Rossi each reports a cure by this method, while Fauro and Loglio each report a fatal case (Suppl. al Policlin., 1900, vi, 30).

I think that a consideration of these results will show us that, so far at least, the treatment of tetanus is extremely unsatisfactory, for while theoretically and for prophylactic reasons the antitetanic serum has undoubtedly proven of the greatest value, as a curative measure after the symptoms have become well developed, the serum does not seem to possess as yet sufficient potency in the great majority of cases; all the evidence seems absolutely opposed to the intracerebral method of injection, as it seems to possess no advantages over the subcutaneous method, and, moreover, is fraught with considerable danger.

A consideration of our case in this connection is instructive, for if it had been treated by any of the other methods, it could certainly have done no better than it did, *i. e.*, resulted in a cure, and it would therefore have been put down as a case successfully treated by that method, while in reality it would have recovered, as it did, under purely symptomatic treatment.

It would seem, therefore, that the rational treatment of tetanus in the present state of our knowledge would be by the use of morphia, bromide and other depressants to the nervous centers, by the

conservation of the strength of the patient, as far as possible, by the application of the most effective dietetic and hygienic methods, while if the case is seen fairly early, it would seem advisable to administer, *by subcutaneous injection*, the antitetanic serum, as it may do some good and certainly can do no harm by this method.

BACTERIOLOGICAL DIAGNOSIS OF TYPHOID FEVER FROM A CLINICAL STANDPOINT.

BY DR. J. HALL PLEASANTS.

The introduction of the Widal reaction in the diagnosis of typhoid fever has been of almost inestimable value to the physician. The fact, however, that in about 5 per cent of cases clinically typhoid this reaction is not obtained, makes any additional exact method of diagnosis most welcome. The conditions under which the Widal reaction may be absent will be mentioned under a brief consideration of the present status of that reaction. A new method of diagnosis based upon the bacteriological examination of the blood, and upon the actual presence of the typhoid bacillus in the blood current has been recently announced and promises to be of the greatest assistance in many cases where the Widal reaction is not conclusive. A brief summary of this new method, together with a short review of the present status of the Widal and other bacteriological methods employed in the diagnosis of typhoid fever clinically, may be of interest.

Determination of the Typhoid Bacillus in the Blood.—While the typhoid bacillus has been demonstrated in the blood *after death* in 9 out of 30 fatal cases of typhoid reported by Vincent, Flexner and others, the results obtained until recently from examination of the blood *during life* have shown a much smaller percentage. Thus out of 117 cases collected by Horton-Smith, in only 7 were organisms found in the blood. The fact that typhoid fever is now known to be a general infection and not merely localized in the intestine, as is shown by the widespread occurrence of the organisms in various parts of the body, and the knowledge that this distribution occurs through the blood current, suggested that more refined methods of technique

would show the presence of the organisms in the blood during life in a larger number of cases. As in other acute infections, there appear in the blood during the course of the disease certain substances which exert a more or less destructive influence upon the specific organisms producing the disease. This inhibitory influence upon the growth of the organism, or even actual bactericidal action, is exerted by the blood after its withdrawal from the body as well as in the circulating blood. This fact has suggested to certain bacteriologists that very large dilutions of the blood taken for examination with fluid culture media would so reduce its bactericidal properties, that organisms if present and living, would no longer be inhibited in their growth, but have a medium suitable for their development. The fact that in most cases the actual number of bacilli in the blood was very small, suggested that the use of a greater amount of blood than was formerly employed would proportionally increase the chances of finding the organisms. Külman, in 1897, working along these lines, and using relatively large amounts of blood (10 cc.) demonstrated the typhoid bacillus by the plate method in 11 out of 41 cases, or in about 25 per cent. But these figures seemed low considering the widespread distribution of the organisms in the body, occurring as they often do in the urine, feces, bile, spleen, lymph glands, bone marrow and lungs even in mild cases, and when we remember that their dissemination has taken place through the blood-channels. Within the past few months three investigators by more refined methods of technique and by the employment of large amounts of blood and great dilutions, have independently obtained results which give promise of furnishing us an important practical aid in the diagnosis of typhoid fever.

Dr. Rufus I. Cole read a most interesting paper before the Johns Hopkins Hospital Medical Society, February 4, 1901, embodying the results of his work along these lines during the past season. This paper has not yet been published, but through the kindness of Dr. Cole I am allowed to present the results of his work and his methods of technique. Blood-cultures were made in 15 unselected cases of typhoid fever. In 11 of these, or in about 75 per cent,

typhoid bacilli were demonstrated. In 3 *mild* cases the bacilli were found as early as on the sixth, tenth and fourteenth day of the disease. Positive results in the 11 cases were obtained from the sixth to the twenty-seventh day of the disease. In 6 cases the bacilli were found in the blood *before* the Widal reaction was positive. In most of the cases the results were positive in the second week. In a few cases more than one examination was made before the organisms were found. In 1 of the 4 negative cases the culture was contaminated, and a second could not be secured. In a second negative case a possible explanation is to be found in the employment of a slightly less dilution than normal. In the remaining two negative cases there is nothing in the technique to explain the result.

The technique employed by Dr. Cole is simple and is based upon three cardinal points: 1. Care in obtaining the blood and in avoiding contamination of the cultures. 2. Use of comparatively large quantities of blood. 3. Extensive dilution of the blood with fluid culture media. The method of procedure is as follows: The bend of the elbow is thoroughly cleaned with soap and water, ether and alcohol. A hot bichloride compress (1-1000) is then applied to the skin for one hour. This not only acts as an efficient skin disinfectant, but also brings the superficial veins into greater prominence. The arm is then compressed below the shoulder to distend the vein further. A small hypodermic needle is introduced quickly into a superficial vein, and 8 to 10 cc. of blood obtained. This blood is then divided among several Erlemeyer flasks containing bouillon, the dilution used varying from 1 to 75 up to 1 to 150—the latter dilution being advised. The flasks are placed in an incubator for 24 hours, and if there is then a growth as shown by cloudiness of the bouillon, transplantations are made upon agar-slants or plates. The identity of the organisms can be established by growth on various media and by agglutination with known typhoid serum, using a dilution of 1 to 50 and a one hour exposure.

At the same time that Cole was carrying on his investigations at the Johns Hopkins Hospital, Schottmüller in Germany, working along similar lines, found the typhoid bacillus present in 40 out of

50 cases (Deut. med. Woch., Aug. 9, 1900). Auerbach and Unger report positive results in 7 out of 10 cases (Deut. med. Woch., Dec. 6, 1900).

Widal Reaction.—Very little of practical importance has been recently added to our knowledge of the Widal reaction. Its application and technique are fully described in all recent text-books. As ordinarily employed, the reaction has diagnostic value in about 95 per cent of cases clinically typhoid. To emphasize the importance of any other method which will assist us in the diagnosis of cases in which the agglutination test is not conclusive, I will briefly summarize some of the weak points in the practical application of the Widal. 1. In about 2 per cent of cases shown to be true typhoid there is no reaction at any time during the course of the disease (Cabot). 2. The appearance of the reaction may be delayed until late in the disease or until convalescence. 3. The reaction is sometimes intermittent from day to day. 4. The reaction may only persist for a few days, and may have permanently disappeared before the test is made, although acute symptoms are still present. 5. In a few persons who have absolutely no history of typhoid, the blood gives the Widal reaction, especially if the dilution is slight. In some of these cases it is impossible to exclude the occurrence of a former mild infection. 6. The reaction in some cases persists for years after an attack, as in Grünbauer's case, where it was present 37 years later. Any fever under these circumstances might be diagnosed as typhoid. This persistence of the reaction in some cases may be caused by such complications as chronic typhoid cholecystitis or an old osteomyelitis. In general, however, the blood begins to lose its agglutinating power in a few months after an attack. 7. Errors in technique are frequent. The line between a positive and a negative reaction is often hard to draw, and whether in a given case definite "clumping" has occurred is frequently a matter of uncertainty.

Notwithstanding these facts, the practical diagnostic value of the Widal reaction is inestimable.

Urine.—Careful studies of the urine show that the typhoid bacillus occurs in from 25 to 30 per cent of all cases. In some of these cases

an actual cystitis may be set up. In an obscure case the bacteriological examination of the urine might give important information. Fortunately, in most of these cases, the organisms occur in pure cultures. The greatest care must be exercised in obtaining the urine. In women careful catheterization under strict aseptic methods can be employed. In men, this is not necessary, but the anterior urethra and glans penis should be carefully irrigated with a bichloride solution. In selecting the urine for examination in both cases avoid the first few drops that are passed.

Feces.—There is no simple and practical method by which the typhoid bacillus can be separated from the other intestinal organisms.

Spleen, Bile and Rose-spots.—Although the typhoid bacillus has been frequently demonstrated in these as in other parts of the body, as yet we have no practical method of making use of this fact for diagnostic purposes. Tapping the spleen has been successfully performed, but is too dangerous to be employed as a routine measure. The same may be said of tapping the gall-bladder. The presence of other organisms in the skin and the resulting frequent contamination of the cultures make a routine examination of the rose-spots of little practical value.

The bacteriological examination of the blood and the Widal reaction are methods to which too much importance cannot be attached. In certain cases the bacilli may be present in the blood before the Widal is positive, thus giving an early diagnosis; or when the Widal is entirely absent, intermittent or of short duration. In uncertain cases where there is an indefinite history of a previous attack of typhoid, or the possibility of the persistence of a local typhoid infection as a chronic cholecystitis, the significance of a positive Widal reaction may be cleared up by a bacteriological examination of the blood.

THE BLOOD IN TYPHOID FEVER, ESPECIALLY CONSIDERING THE LEUCOCYTES, AND PERFORATION AS A COMPLICATION.*

By CHARLES H. BRUECKNER, '01.

The purpose of this brief article is to particularly show the value of examining the blood and counting the leucocytes in all cases of typhoid fever, in order to note any increase or decrease in their number. The red cells and the hemoglobin, although considered, will be dismissed in a few words, as nothing of very special importance is learned by their study. The consideration of perforation as a complication in the course of typhoid fever will be treated after considering the leucocytes.

The Red Cells.—In the first two weeks no considerable changes are noticed, except an apparent increase of the red cells in cases where a certain amount of concentration of the blood occurs, due to the elimination of the watery elements in diarrhea or sweating. Baths have a similar effect if the blood is examined immediately after immersion. During the third week a marked diminution of the red cells may take place, the decrease being dependent on the severity of the attack; in protracted cases a severe grade of anemia is noted.

Though a decrease in the number of red cells is noted in all cases, in some it is only slight; while a count of two and a half million to the cubic millimeter is not uncommon, in extreme cases the count may be as low as 1,300,000 to the cubic millimeter at the beginning of convalescence. Hayem observed that the diminution is rather sudden during the middle or end of the third week of severe cases; according to Thayer the decrease is gradual and most marked at the beginning of convalescence. When the temperature is kept low by baths, the decrease is less marked.

The hemoglobin is reduced in amount in proportion to the reduction of the red corpuscles.

The Eberth Bacillus in the Blood of Typhoid Patients.—Th. Janowski reports a number of observations made by a dozen or more different observers, of the blood of typhoid patients with the

* Read at the final meeting (Session 1900-1901) of the Medical Society of the College of Physicians and Surgeons, Baltimore, Md., March 18, 1901.

hope of finding the Eberth bacillus. The results were negative in all cases except the experiments of Neuhaus of 15 cases of typhoid. He made four stroke cultures of the blood from the rose-spots and four cultures of the blood from the pad of the finger. On nine cultures all of different patients, colonies developed which were found to be typhoid bacilli, proper control tests having been made. Lively interest was excited by these results and led many others to work on these same lines, but with a larger number of cases in the hope of establishing the finding of the bacillus in the blood of diagnostic value. All the researches following those of Neuhaus failed to find the bacillus in the blood in any case. Dr. Cole reported at February meeting of the Johns Hopkins Medical Society results of a careful study of eleven cases, in six of which he found the typhoid bacillus, at a period earlier than it was possible to obtain the Widal test. In one case as early as 24 hours.

The Leucocytes.—With the exception of the Widal test, the most important feature in the consideration of the blood in typhoid fever is the absence of any increase in the number of white cells. When we consider the great increase in the number of leucocytes in some of the diseases of the lymphatic tissues, *i. e.*, Lymphatic Leukemia, in which the lymphocytes, both large and small, are increased to 65 per cent, and in not a few cases to 95 per cent or more of the white cells, we would expect an increase in the number of leucocytes in typhoid fever where there is a stimulation of the lymphatic tissues of the intestine—the solitary and agminated glands—causing a distinct hyperplasia. All observers now agree that there is no leucocytosis in uncomplicated typhoid fever, though there is a slight relative increase in the large mononuclear variety. In the earlier literature cases of typhoid fever are reported in which the observers noticed a leucocytosis, but no mention is made whether or not these cases were complicated. The observations of such authorities on Hematology as Grawitz and von Limbeck seem to show conclusively an absence of any leucocytosis in a large number of cases of uncomplicated typhoid fever. Grawitz agrees with von Jaksch in that all cases of leucocytosis in typhoid fever are due to some complication, as pneumonia, suppurative processes, perforation, etc., while von

Limbeck and Rieder cite cases of typhoid fever complicated by croupous pneumonia and hemorrhage conditions in which a leucocytosis is the rule, without noting any effect on the leucocyte count.

The literature of these observers could not be had in order to more fully study the complications as to whether they were mild cases and the resisting power of the patient was good, in which cases only a very slight leucocytosis is produced; or, whether they were severe cases and the resistance of the patient was poor, in which cases no leucocytosis occurs.

The number of white cells falls during the fever, according to Hayem, below 2000 per cubic millimeter, and on rare occasions to below 1000. Thayer's figures based on a large number of counts, show a decrease in the number of leucocytes during the progress of the disease, and 491 cases at the Massachusetts General Hospital corroborate Thayer's figures of the decrease in the number of the white cells, both, however, being less in the diminution than in Hayem's cases.

At the beginning of these 491 cases, the count in some was often as high as 11,000, owing probably to a concentration of the blood by a diarrhea or sweating. The high count of the red cells confirmed this view of the cause of this increase in white cells, the ratio of the white to the red remaining normal. In some of the cases where the count was high, or a leucocytosis constantly existed, Cabot was inclined to the belief that some complication was present though unrecognized, as perhaps the possibility of a secondary septic infection as an osteomyelitis or a phlebitis of an internal vein. Rieder noted a fall in the number of the white cells after a relapse or an exhausting attack, and he referred to the absence of any leucocytosis and a fall in some cases, as being of value in the diagnosis of typhoid fever from meningitis, pneumonia and many other conditions presenting typhoidal symptoms, but always associated with a leucocytosis.

The question might suggest itself to the close observer, what is the cause of this absence of any increase in the number of white cells? No satisfactory explanation has as yet been offered; von Limbeck advanced the theory that Inanition is the cause, but this view is not supported by others.

The diagnosis of typhoid fever by the blood examination is frequently difficult owing to the frequent complications of this disease and their associated leucocytosis. In consideration of the differential diagnosis of typhoid by the counting of the white cells it seems rather important to keep in mind:

1. Is it a case of uncomplicated typhoid?
2. Is the complication one usually associated with leucocytosis?
3. Is the complication mild, or of great severity, and what is the resistance of the patient?

Cabot is of the opinion that complications due to the Eberth bacillus, *i. e.*, Eberth-pneumonia or Eberth-cystitis, do not affect the leucocyte count. He hopes to investigate this point more fully. It might be inferred from this assertion of Cabot that the complicated cases of typhoid mentioned by von Limbeck in which he found no leucocytosis, might have been caused by the Eberth-bacillus; but this does not explain the absence of any leucocytosis in Rieder's case which was complicated by hemorrhage. Aporti and Radaelli have noted a slight increase in the leucocyte count at the beginning of convalescence. Thayer and Cabot did not find this, however.

Complicated cases of typhoid fever showing no leucocytosis are exceptional, and in many of them the percentage of the polymorphonuclear forms arises, though no increase in the total leucocyte count is present. It will be remembered that the polymorphonuclear forms are diminished and the mononuclear forms are relatively increased in uncomplicated typhoid fever. If a differential count is made, an increase in the polymorphonuclear forms generally betrays the presence of the complication. After subsidence of the fever, the blood begins to return to normal in the sixth or seventh week.

A differential count of the white cells in ordinary uncomplicated typhoid shows a progressive decrease in the percentage of the polymorphonuclear leucocytes (neutrophiles) with a corresponding increase in the lymphocytes (large and small) the larger forms predominating. During the first two weeks this change is slight, but it becomes more marked as the disease progresses. Eosinophiles are present in small numbers.

Leucocytosis following the cold bath was clearly demonstrated by

Thayer in a series of 20 cases of typhoid fever, the leucocytosis, however, being only transient; it occurs also in healthy individuals after the bath. In 8 of the 20 cases an increase from 8000 before to 10,437 after the bath, the exact time between the count before and after the bath was not noted. In the remaining 12 cases the average increase was from 7541 to 14,492, possibly a shorter time elapsed between the bath and the second count in the first eight cases. Two observations were made of a healthy individual (Thayer experimented on himself). In the first experiment the bath lasted 20 minutes, after which he was warm and red, but not shivering; the leucocyte count rose from 10,333 to 12,333. In the second experiment the bath was colder, and lasted 22 minutes, after which he was cyanosed and shivering, the count increased from 3250 to 12,500.

The large mononuclear forms increased while the polymorphonuclear forms decreased. In one case the transitional forms were increased and the large mononuclear forms decreased. In the first experiment of Thayer on himself there was very little change, which is all the more striking when we consider the great increase in the number of white cells (nearly four-fold) in his second experiment.

Cyanosis and coldness seem to bear some importance to the increase in the number of leucocytes after the cold bath, as will be noted by Thayer's first experiment in which cyanosis and coldness were present and an increase in the number of white cells occurred; and the absence of coldness and cyanosis in one of the 20 cases in which there was a diminution in the number of leucocytes.

Some of the points to be worked out in the examination of the blood in its relation to the increase of the white cells following the cold bath are:

Does the blood from parts cold and blue show the same condition as blood from parts red and warm?

Does blood from a superficial cut show the same condition as blood from a deep needle prick, or possibly from a large vein?

Do local applications of cold bring about the same results in the part as the more general baths?

Summary of the findings of the blood examination:

1. Post-febrile anemia; sometimes very intense.
2. No leucocytosis; in late weeks leucopenia.
3. Increased percentage of lymphocytes at the expense of the polymorphonuclear forms; especially marked in later weeks.
4. Most complications cause a leucocytosis.

Diagnostic Value of Blood Examination.—Outside of the diseases of the blood itself, there are few diseases in which the leucocyte-count is so often of value in diagnosis. The diagnosis is to be made by exclusion and in this process of exclusion the blood is a most powerful adjuvant, inasmuch as almost all local inflammatory processes have a leucocytosis, while typhoid, when uncomplicated, does not. It is in most early cases in which the diagnosis is especially important and difficult, that the blood shows no leucocytosis, and is, therefore, of great value in the exclusion of other diseases.

Perforation.—Thus far little reference has been made to perforation as a complication of typhoid, as it was deemed better to treat of it in a separate part.

It is the most important and most fatal part of all the complications and the one that requires the greatest care and attention. On its prompt and early recognition by the symptoms and careful blood examination which shows a marked increase of leucocytes, depends the patient's chances of recovery, for now, with the aid of rapid and improved methods of blood counting, many cases are saved by early surgical procedure that formerly went to the post-mortem table. Of Osler's 685 cases of typhoid, 4.96 per cent were complicated by perforation; Fitz tabulated 4680 cases, in 6.58 per cent of which perforation occurred. It is most common at the end of the second week or in the third week, though the time of its occurrence varies from the eighth day to the sixth week, at times occurring after the subsidence of the fever. It may be looked for by the sudden appearance of an acute pain in the abdomen, and the symptoms of collapse. If in these cases the blood is examined, the number of leucocytes will be greatly increased.

There is no doubt that many cases of typhoid have a fatal termination from an unrecognized perforation, due to the fact that either the symptoms are so slight that they are not suggestive of perforation, or the effects of perforation are so rapid that death ensues before this condition is even suspected, and is found accidentally post-mortem. Osler mentions many such cases that were found accidentally. In those cases with an abrupt and well-defined onset the diagnosis of perforation is simple even without the blood-count, though the latter is a valuable aid in diagnosis. In cases in which the onset is gradual and the symptoms are ill-defined, if uncomplicated, the finding of leucocytosis is a very valuable index of perforation, and a good indication of the need of surgical interference.

There is a small group of cases where there are no symptoms whatever of perforation, the local features being masked by the severe toxemia. It is in this latter group that the regular and systematic examination of the blood often detects a leucocytosis which gives the first clue of an approaching perforation. The diagnosis by the blood-count was demonstrated by Thayer in Osler's wards.

While discussing the value of the blood-count in perforation, complicating typhoid fever, Dr. Brown cited the case of a patient whose life was no doubt saved by a regular and careful count of the white cells. There was little in the symptoms suggestive of perforation, but a few counts of the leucocytes increasing in numbers at each count, indicated the advisability of a cœliotomy for the repair of damage done by perforation. The surgeon opened the abdomen and found perforation of the bowel at the seat of a typhoid ulcer which in a few hours would probably have resulted in a general peritonitis, followed by death.

THE DIAGNOSIS OF GONORRHOÆAL PROSTATITIS.

By DR. W. B. WOLF, '96.

The more we have accustomed ourselves in late years to emphasize the localization of gonorrhœa in the male, the more has our special attention been directed to the effect of this disease upon the prostatic gland.

Authorities in this special branch still differ as to the frequency with which the prostate is affected by gonorrhœa, but we can say to-day positively that prostatitis is very often, if not always, a complication of gonorrhœa. This is so often the case that in every case of posterior urethritis one should never neglect to examine the prostate, and it will be found that in a large percentage of cases the prostate is usually affected. Of great importance in the diagnosis of gonorrhœal prostatitis, its treatment and, above all things, the danger of infection, is the proof of gonococci in the prostatic secretion, and as in anterior urethritis, only by frequent microscopic examinations are we able to tell whether gonococci are present, just as in similar manner only by microscopic examination of the prostatic secretion are we able to state whether infection is present.

It must be clear to us from the very beginning that it is comparatively much more difficult on account of the fact of our inability to locate the affected area in the prostate and to obtain the expressed secretion.

In comparison the microscopic examination of the prostatic secretion is far more important than the macroscopic appearance of the secretion, and also than the rectal examination of the prostate; therefore it is necessary for us to use all methods at our command by means of which we can obtain pure prostatic secretion.

In order to accomplish this we have two methods; one is the examination of the prostatic secretion by expression, and the other the examination of the "Expressions Urine," as Von Schlen, Posner, Krotoshine and others have termed it. The first method is by examining the affected part of the prostate per rectum, and through slight pressure on same press out the secretion, which appears then at the meatus, from which we can make a smear and examine according to the usual standing method.

The second method, the examination of the "Expressions Urine," is made by letting the patient retain part of the urine in the bladder until we have massaged the prostate; then we allow the patient to void the retained urine mixed with the expressed prostatic secretion; this we sediment with the centrifuge, make a smear and, when dry, stain and examine microscopically.

It is important for us to know whether the first or second methods give us the most exact results, and I believe to be able to solve this question more closely in the following way; I have examined the material in the Berlin Poliklinik for the treatment of genito-urinary diseases, and in my own practice, according to both methods side by side.

I have examined 7 cases in all, according to this manner, the history of each I will briefly give below, and came to the following conclusion: In 4 of these cases the microscopic examination of the expressed prostatic secretion, and of the "Expressions Urine" gave the same results, and in 3 cases where the prostatic secretion could not be brought to the meatus a positive diagnosis was made through the examination of the "Expressions Urine."

If I am now allowed to express an opinion from the examination of these few cases, it is that in the most of cases of prostatitis we can be satisfied with the examination of the expressed prostatic secretion; but in those cases where the prostatic secretion does not appear at the meatus after massage, which is due to the spasmodic contraction of the musculo compressor, the microscopical examination of the "Expressions Urine" should never be neglected.

No. 1. R., clerk, had gonorrhœa since January, 1900, came for treatment March 12, 1900. Anterior secretion contains extra and

intracellular gonococci. Urine 1 and 2 cloudy. Prostate right side enlarged and slightly above the middle a softened area. Expressed prostatic secretion could not be obtained. "Expressions Urine" contains gonococci and pus cells and staphylococci.

No. 2. L. Has never had any genito-urinary disease. Last intercourse five days ago, and in the last five days has had a discharge which contains gonococci extra and intracellular, and pus cells. Urine 1 and 2 cloudy. Prostate on both sides enlarged, left lobe above and in the middle a soft area. Prostatic secretion contains pus cells and gonococci. "Expressions Urine" the same.

No. 3. D. Had gonorrhœa 7 months ago, since January 8. Has had a discharge which contains extra and intracellular gonococci. Urine 1 and 2 cloudy. Prostate enlarged on both sides and somewhat softened. Expressed secretion contains pus cells and gonococci and diplococci not decolorized by Gram's method.

No. 4. L. Had gonorrhœa for about one year, claimed to have been cured. For the last four months has noticed a slight discharge in the morning, which contains epithelial and pus cells. Urine 1 and 2 flaky. Prostate right and left lobe enlarged, very sensitive, right seminal vesical also enlarged. Prostatic could not be obtained. "Expressions Urine" contains extracellular gonococci and diplococci, not discolorized by Gram's method and pus cells.

No. 5. G. Had gonorrhœa July, 1900; was treated with anterior injections for about six weeks with little results; then he gave up treatment entirely until about a month ago. The discharge was scanty, which contains pus and epithelial cells. Urine 1 and 2 cloudy. Prostate, left lobe was larger than right lobe and decidedly more sensitive. Expressed prostatic secretion contains gonococci, staphylococci and pus cells. "Expressions Urine" contains pus cells and gonococci.

No. 6. W. First case of gonorrhœa about eight years ago. For the last three weeks noticed discharge. Urine 1 and 2 cloudy. Anterior secretion contains extra and intracellular gonococci and pus cells. Prostate right and left lobe enlarged. Prostatic secretion could not be obtained. "Expressions Urine" contains pus cells and gonococci.

No. 7. Sp. Has discharge for two months. Anterior secretion contains bacteria and pus cells. Urine 1 cloudy, 2 clear, with exception of shreds. Prostate right lobe enlarged, sensitive and has about the middle a soft area. Expressed prostatic secretion contains gonococci, diplococci and pus cells. "Expressions Urine" the same.

WILLIAM S. GARDNER, M. D., EDITOR,
1012 McCulloh Street,
Telephone 799 M.

WILLIAM J. TODD, M. D., BUSINESS MANAGER,
Postal Station No. 202.
Telephone, C. & P., Tuxedo, No. 303.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

POST-GRADUATE COURSES FOR ALUMNI.

Year after year alumni return to college anxious to add to their stock of knowledge, to freshen their minds on subjects which have grown rusty and, particularly, to study methods of clinical examination and of laboratory work which have been developed since their college days. Some return to devote a little time to some special branch in medicine, others to benefit themselves by study and observation of the large and ever-increasing medical and surgical material of our hospitals. A few private courses may be arranged, but usually the work is less satisfactory than it should be, because there is no systematic work laid out for post-graduates.

The frequent requests from alumni, the evident need of properly arranged courses, have led the College to prepare a systematic set of post-graduate courses for the spring of 1902, to begin immediately at the close of the regular session.

The post-graduate courses will begin April 28th and last for six weeks. They will embrace medicine and surgery with their subdivisions, the various specialties, as well as laboratory courses in bacteriology, pathology and clinical laboratory work. The courses are arranged to occupy the post-graduate, whose time is valuable and who wishes to do as much work as he can do properly and satisfac-

torily from 9 A. M. to 5 P. M., though the student will be at liberty to choose as much or as little as he desires to. It is unnecessary to state that all of the courses laid out are entirely practical.

In medicine there will be daily clinics and daily visits to the wards. There will be daily clinics in general surgery and gynecology. Each specialty will give a course of about twelve lessons, and these will include operative obstetrics, laryngology, ophthalmoscopy, genito-urinary surgery and cystoscopy, etc.

The laboratory courses will be held in the afternoon, so as not to conflict with the clinical courses, and will be as thorough and complete as possible. Definite announcements will be made later in this JOURNAL.

The teaching staff look forward to these post-graduate courses with much enthusiasm and pleasure at the thought of again meeting many of their old students about the bedside, in the operating room or at a table in the laboratory.

H. F.

THE eleventh and twelfth annual reports of Adrian Hospital, Punxatawny, Pa., for the two years ending September 30, 1900, has been received.

The medical and surgical staff include S. M. Free, '80; T. R. Williams, '82; C. W. Hughes, '87; W. S. Blaisdell, '90; Charles L. Maine, '92; and the resident physician, A. W. Clark, '95. Dr. Cooley is the only member of the staff who is not a member of the Alumni Association. They are doing a large amount of both medical and surgical work, and secure excellent results.

AMONG the interesting features of the recent meeting of the American Medical Association was an historical exhibit of ophthalmoscopes prepared by Dr. Harry Friedenwald. The exhibit was arranged to commemorate the 50th anniversary of the invention of the ophthalmoscope in 1851 by Helmholtz. Among the 140 instruments shown there were many of the oldest and rare forms, including models of the original instrument as described by Helmholtz. Dr.

Friedenwald also delivered an address on the History of the Invention and the Development of the Ophthalmoscope, followed by an address by Dr. Carey Wood, of Chicago, on the Life of Helmholtz.

The following announcement of prize men and hospital appointments were made at the Commencement:

COLLEGE PRIZES.

Chas. H. Brueckner, N. J.—First Prize.....(Gold Medal.)
 V. G. Williams, Ga.—Second Prize.....(Gold Medal.)
 Seeber King, Fla.—Third Prize.....(Gold Medal.)
 J. M. Barry, Canada.—Fourth Prize.....(Gold Medal.)

WORTHY OF HONORABLE MENTION.

H. R. McGraw, Utah.	S. T. Lowry, Texas.
E. M. Pearcy, W. Va.	J. J. Bell, Pa.
L. J. Rosenthal, Md.	A. B. Vanderbeek, N. J.

HOSPITAL APPOINTMENTS.

BALTIMORE CITY HOSPITAL.

Dr. H. Louis Stick.....Resident Physician.
 Dr. L. J. Owen.....Associate Resident Physician.
 Dr. C. W. G. Rohrer.....Associate Resident Physician.
 Dr. J. M. Barry.....First Assistant Resident Physician.
 Dr. F. T. Marr.....Second Assistant Resident Physician.
 Dr. L. J. Rosenthal.....Third Assistant Resident Physician.
 Dr. Jas. L. Sullivan.....Fourth Assistant Resident Physician.
 Dr. H. B. Jester.....Fifth Assistant Resident Physician.
 Dr. Albert F. Conrey.....Sixth Assistant Resident Physician.
 Dr. E. T. West.....Assistant in Pasteur Department.

MATERNITE HOSPITAL.

Dr. S. T. Lowry.....Resident Physician, Indoor Department.
 Dr. W. B. Graves.....Resident Physician, Outdoor Department.

BAY VIEW ASYLUM.

Dr. N. G. Keirle, Jr....Medical Superintendent.
 Dr. W. B. T. Smith....Resident Physician.

Personal Notes.

DR. W. L. QUINN, '96, is practicing at Fayette City, Pa.

DR. LEO F. ELSTEIN, '85, has a flourishing practice at Allentown, Pa.

DR. CLARENCE GARRABRANT, '86, is located at Atlantic City, N. J.

DR. J. F. MCGREW, '88, died at Finleyville, Pa., February, 1901.

DR. D. W. SHIRKEY, '90, is now practicing at Walton, Roane County, West Virginia.

DR. FRED W. MANN, '92, is now practicing in Haulton, Me. Monticello was too small for him.

DR. EDWIN KIRKPATRICK, '86, who began his practice at Americus, Kansas, is now at Peatone, Ill.

DR. J. H. BERST, '82, who has been practicing at Kokomo, Ind., has located at East Saginaw, Mich.

DR. HUGH M. LOGAN, '79, who has been practicing at Rectortown, has recently moved to Rileyville, Va.

DR. C. CYRUS DICK, '93, is located at Altoona, Pa. He makes a specialty of diseases of the eye, ear and throat.

DR. W. C. MCCURDY, '74, has moved to Cardiff, Md. The doctor is one of the regular attendants of all alumni meetings.

DR. W. S. EUBANKS, '91, has removed from Blockville to Talatha, Aiken County, S. C.

DR. MARIUS E. ROBINSON, '70, of Goldsborough, N. C., is City Physician, and medical examiner for various orders and insurance companies.

DR. D. S. ELLIS, '79, practiced for twelve years after his graduation in Northampton County, N. C. For the past eight years he has been physician to Randolph-Macon College.

DR. MEIGS J. BARTLETT, '95, of Clarksburg, W. Va., was among the number who attended the annual banquet of the Alumni Association. He is meeting with great success in his practice.

DR. H. BASCOM WEAVER, '72, is located at Asheville, N. C. He is a charter member of the Buncombe County Medical Society and ex-secretary and treasurer of the State Board of Medical Examiners.

DR. WM. H. CRAIG, '86, has a flourishing practice at North Ontario, California. He is a member of the American Medical Association and medical examiner for half a dozen life insurance companies.

DR. CHAS. EMIL BRACK, '95, was married to Miss Mary A. Grob, Sunday, June 9th, by the Rev. John B. Boland. Dr. Frank Dyer Sanger, '88, was best man. A reception was given, after which the couple went North for a tour.

AT the meeting of the American Medical Association at St. Paul a number of alumni were present. Among them were:

DR. L. F. ANKRIM, '85, of Pittsburgh. He is unchanged by the sixteen years that have passed since graduation.

DR. A. G. ALDRICH, '79, has a flourishing practice in Minneapolis.

DR. O. F. KISTLER, who was a student at the College in '86, has an excellent practice at Wilkesbarre, Pa., and is giving special attention to diseases of the eye and ear.

DR. CARROLL D. EVANS, '82, of Columbus, Neb., was appointed surgeon-general of the Nebraska national guard by Governor Savage. The doctor has served on the staff of Governor Dietrich, but will certainly consider his appointment to the head of the medical department a great compliment and a promotion, although his rank is not

higher than before. General Killian asserted with great satisfaction that it was a pleasure to him to countersign the colonel's new commission and handed it to him in person last evening.

DR. JOHN RUHRÄH, '94, who has been in Europe for the past year, writes of some of his recent experiences as follows:

"The Ruhräh-Rosenthal Continental Touring Combination was forced to separate, as Rosy wanted to remain in Der Vaterland while I had longings for Gay Paree. I have been here almost a month and have hopes of finding out something before I leave.

The things medical are very good here, but not so well arranged for the foreigner as in Germany or Austria. They have sufficient French students, and as almost everything is free here they don't worry about the stranger and his shekels. It is strange that they do not try to take him in, but so far I have seen or heard of no bunco medical instruction such as is rampant in the German centers—Berlin at any rate.

The French hospitals are old for the most part, not particularly inviting always because of their age, but clean on the inside and the patients well cared for. The clinics are, for the most part, at the same hour, so one cannot get neurasthenia if he sticks to the clinics. They are well arranged and one always learns something. In Germany much of the instruction is eminently suited for the advanced. I heard many lectures for students that were so far ahead of what the average student could really grasp that I doubted their efficiency as a means of training a man at the start. Here the majority of the student instruction seems to be at the bedside. They divide the students up among the hospitals and they work in the wards. They make the visit with the physician (generally a professor) in charge of the wards and otherwise work under the direction of the internes. I attended some of the ward visits in the hospitals and should like to see the same thing done more with us.

Just at present there is a lull between the semesters, and I go every evening to the Salpêtrière and go around with Professor Dejardine,

for which God bless Dr. Osler. Four days a week he does the wards and one day the dispensary. They have nearly four thousand patients in the Salpêtrière, but many are insane or old chronics of little interest. The dispensary is almost purely nervous, and one of the heads of the various departments has it each day.

He has about three hundred cases under his care, and he walks through half his wards each day and sees each case personally, although the majority are chronic cases which are waiting for autopsy, as it were. It is a pity Bay View is not utilized in the same way. One trots at such a pace that one does not gather great bunches of knowledge from the plants of wisdom which he waters with his magical words, but I get a bit each morning and trust I shall know our old friend locomotor A. when I see him in his classic form.

Sometimes he does a hypnotic turn on a patient, sometimes a word on a syringomyelia or a scleroderma, and sometimes he gets into the deep waters of nervous physiology and pathology and then I just wait until he gets into shallow water again. So far I have just looked and listened, but as soon as I become a little better acquainted I want to worry the patients on my own hook, all of which he says I may do.

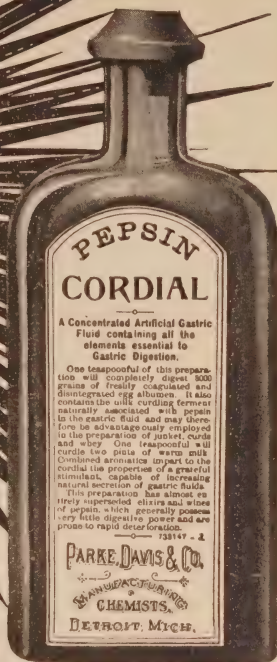
DR. F. J. SNYDER, '87, of Jacobus, Pa., gives the following interesting account of "The Feast of Roses" of Manheim, Pa.:

Believing that a brief history of what has led up to the observance of a most beautiful and unique ceremony, in which one of our alumni has been, and is now, playing an important rôle, would be of interest to the readers of our valuable JOURNAL, I submit the following: Probably the most romantic and pathetic life history in the early annals of the State of Pennsylvania had its birth on the arrival of Baron Henry William Steigel in Philadelphia from Germany in 1750. During the days of prosperity that followed his many successful ventures, Baron Steigel was beyond doubt one of the richest and most prominent men in Pennsylvania, and probably the largest land-owner in the province. Ever solicitous of the happiness and comfort of his workmen, in his conscientious regard for their spiritual

welfare, he frequently preached to them himself, presenting them with a church site on which he built a church for them. In conveying this church property to the inhabitants of Manheim no consideration was asked for it save the sum of five shillings (the amount required by law to make the transaction valid) and the curious obligation set forth in the deed in due legal form, requiring the congregation to yield and pay therefrom unto the said Henry William Steigel, his heirs or assigns at the town of Manheim, in the month of June, yearly, hereafter, the rent of one Red Rose if the same shall be lawfully demanded. Twice was this rent paid to the Baron himself, and then for a period of nearly one hundred and twenty years the deed and its strange stipulation were lost sight of. The rent was not demanded, and it was gradually forgotten, until it became a mere tradition in the town's history. Strangely enough, no attempt was ever made to investigate the source or truth of this tradition until about 9 or 10 years ago, when the town historian, Dr. J. H. Sieling (an alumnus), a man to whom the world owes much for its knowledge of Baron Steigel, found the deed and learned that this tradition was a true one. He proceeded to find the nearest lineal descendant, and preparations were accordingly made for the first celebration of the "Feast of Roses," in honor of the memory of Baron Steigel and in commemoration of the payment to him of his yearly rent. The novelty and beauty of the event have since spread, until now the second Sunday of June of each year causes Manheim to be the Mecca for a large number of people for many miles around this historic town. This year the rent of one Red Rose was paid to Miss Annie Boyer, of Harrisburg, Pa.

DR. HUBERT C. KNAPP, '96, and Miss Margaret Raub Hubert, were married in Washington, D. C., June 25, 1901.

This Month and the Next.

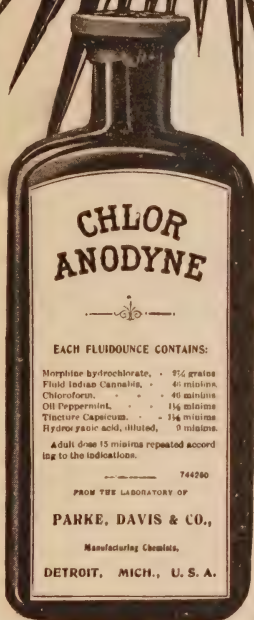


PEPSIN CORDIAL.

Invaluable in the treatment of infantile diarrhea when caused by partly digested or fermenting milk and other food.

Our Pepsin Cordial is an elegant preparation, therapeutically active, furthermore absolutely permanent, and in digestive power one teaspoonful will dissolve 2000 grains of coagulated egg albumen.

Literature on application.
In 5-pint and 8-oz. bottles.



EVERY
PHYSICIAN
SHOULD
PRESCRIBE
THESE.

CHLOR-ANODYNE

There is no better remedy for Colic, Cholera Morbus, Diarrhea, Dysentery, Cramps, Spasmodic Pains, and the numerous Bowel Troubles encountered in summer.

In pint, half-pint, and quarter-pint bottles, also ounce vials.

HOME OFFICES,
& LABORATORIES
DETROIT, MICH.,
BRANCH LABORATORIES,
HOUSLOW, ENG. AND
WALKERVILLE, ONT.

PARKE, DAVIS & Co.

BRANCHES IN
NEW YORK, KANSAS CITY,
BALTIMORE, NEW ORLEANS
CHICAGO, LONDON, ENG.
& MONTREAL, QUE.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, N. Y., Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S. Ohio.
E. PABMPLY BROWN, D. D. S. N. Y.
A. L. NORTHROP, D. D. S. N. Y.
E. L. HUNTER, D. D. S. N. C.
W. W. WALKER, D. D. S. N. Y.
OSCAR ADELBURG, D. D. S. N. J.
G. MARSHALL SMITH, D. D. S. Md.
C. M. GINGRICH, D. D. S., Resident. Md.
J. HALL MOORE, D. D. S. Va.

R. B. DONALDSON, D. D. S. D. C.
H. A. PARR, D. D. S. N. Y.
J. EMORY SCOTT, D. D. S. Md.
C. L. ALEXANDER, D. D. S. N. C.
M. M. MAINE, D. D. S. Conn.
J. W. DAVID, D. D. S. Texas.
A. C. BREWER, D. D. S. Md.
J. ROACH, D. D. S. Md.

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

W. W. DUNBRACCO, D. D. S. J. K. BURGESS, D. D. S. J. C. SUTHERLAND, D. D. S.
GEO. V. MILHOLLAND, D. D. S. CHAS. THEBERATH, D. D. S.
L. M. PARSONS, D. D. S. HARRY E. KELSEY, D. D. S. C. H. CARSON, D. D. S.
H. M. LEVER, D. D. S. C. S. GORE, D. D. S. L. F. PALMER, D. D. S.
C. R. STEWART, D. D. S. L. D. CORIELL, D. D. S.
H. H. HAYDEN, M. D., Demonstrator of Anatomy.
C. F. BLAKE, M. D., Demonstrator of Anatomy.

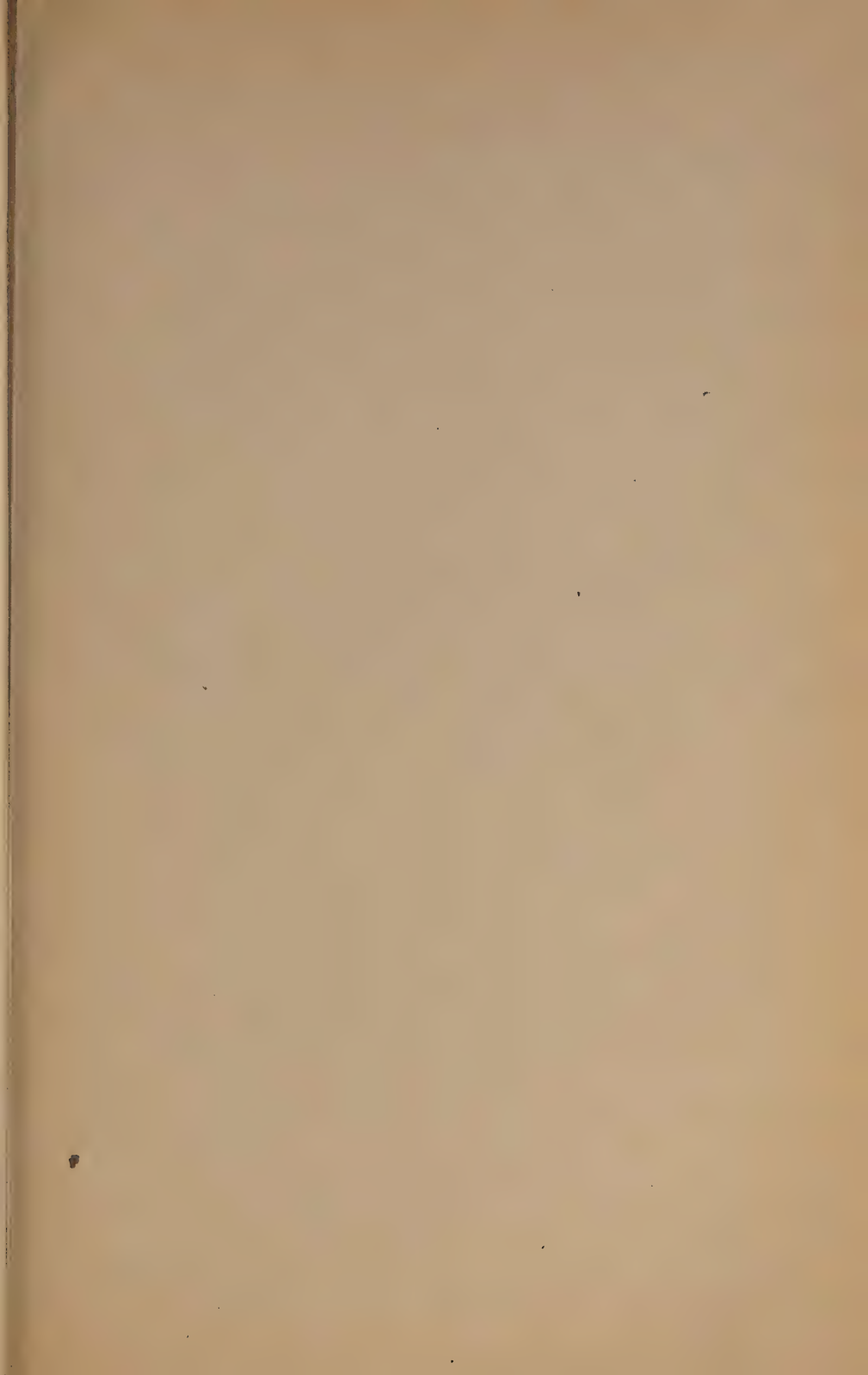
The Sixty-First Annual Session will commence on the 1st of October, 1900, and continue until May, 1901.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.



College of Physicians and Surgeons OF BALTIMORE.

—FACULTY—

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- AARON FRIEDENWALD, M. D.,
Professor of Diseases of the Eye and Ear.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Pathology and Medical Jurisprudence.
- C. HAMPSON JONES, M.B., C.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, M. D.,
Professor of Obstetrics.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- W. F. SMITH, A. B., M. D.,
Associate Professor of Surgical Anatomy.
- B. HOLLY SMITH, M. D., D.D.S.,
Professor of Principles and Practice of Dental Surgery as applied to Medicine.
- HARRY FRIEDENWALD, A. B., M. D.,
Associate Professor of Diseases of the Eye and Ear.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MCLEARY, M. D.,
Associate Professor of Physiology and Demonstrator of Histology and Pathology.
- CHARLES E. BRACK, M. D.,
Associate Professor of Obstetrics and Lecturer on Pharmacy.
- JOHN RUHRÄH, M. D.,
Associate Professor of Diseases of Children and Demonstrator of Pathology.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy and Demonstrator of Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Assistant Demonstrator of Anatomy.
- SYLVAN H. LIKES, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MOGLANNAN, M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- ALBERTUS COTTON, M. D.,
Demonstrator of Surgery and Assistant Demonstrator of Anatomy.
- GLENN M. LITSINGER, M. D.,
Demonstrator of Obstetrics.
- M. EKSTRÖMER, M. D.,
Demonstrator of Chemistry.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- SYLVAN ROSENHEIM, M. D.,
Demonstrator of Bacteriology.
- ARCHIBALD C. HARRISON, M. D.,
Assistant Demonstrator of Anatomy.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Clinical Assistant in Gynecology.
- W. B. WOLF, M. D.,
Demonstrator in Clinical Laboratory.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- S. S. HOULTON, M. D.,
Assistant in Diseases of Stomach.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Table of Contents Page VII.

Issued Quarterly

Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS
BALTIMORE.

Vol. IV

No. 3

OCTOBER, 1901

PUBLISHED AT
Baltimore and Eutaw Sts. Baltimore, Md.

GIVES BEST RESULTS

MULFORD'S ANTITOXIN

PHILADELPHIA, CHICAGO



**H. K. MULFORD
COMPANY
CHEMISTS**

Mulford's Glycerinized Vaccine

is prepared with every possible aseptic precaution. Each separate yield is subjected to the most rigid tests. It is guaranteed to succeed in 100 per cent. of primary cases, and retains its activity at least six months.

The virus from absolutely healthy animals only is employed, and each separate yield is subjected to the most rigid Physiologic and Bacteriologic tests.

H. K. MULFORD CO.

Chemists

PHILADELPHIA

CHICAGO

Case of 10 tubes—10 vaccinations—\$1.00. Mailed upon receipt of price. Write for literature.

The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,
CATONSVILLE, MD.

REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
Extract from the Introductory Address: Session of 1901-2. DR. W. F. LOCKWOOD.	65
Gonorrhea as a Social Problem. DR. W. L. CHAMPION,	71
Upon the importance of Early Diagnosis of Tuberculosis of the Larynx. DR. FRANK DYER SANGER,	75
Gauze Drainage in Infection of the Puerperal Uterus. DR. WILLIAM S. GARDNER, .	80
Acute Dilatation of the Stomach. DR. JULIUS FRIEDENWALD,	83
Editorial,	89
Personal Notes,	iv, 90
Correspondence,	92
BOOK NOTICE,	96

**"OUR
LEADER."**

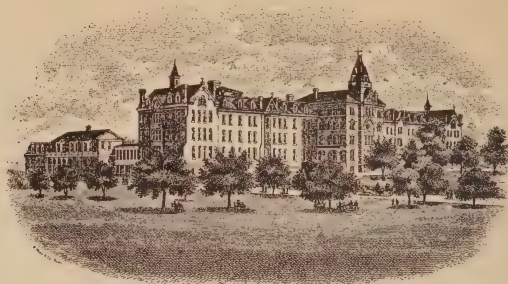
Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.



All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,
 BENJ. A. NELSON, General Manager,
MANUFACTURERS AND IMPORTERS,
300 N. HOWARD STREET, - - - BALTIMORE, MD.
 PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES.

ST. AGNES' SANITARIUM.



This Institution is beautifully situated on high, rolling ground, just outside Baltimore, and overlooking the Bay. It is thoroughly equipped as a modern Sanitarium for the treatment of Nervous Diseases and Drug Habits (no mental cases received). A complete Hydrotherapeutic Establishment has been recently added. Electric outfit, Gymnasium, Massage by trained operators, Sun Parlors, Billiard Rooms, Tennis, Golf, &c.

Medical Director, George J. Preston, M. D., Professor of Nervous Diseases, College of Physicians and Surgeons, Baltimore.

For further information, terms, &c., address

THE SISTER SUPERIOR,

St. Agnes' Sanitarium, Carroll P. O., Baltimore, Md.

Personal Notes.

DR. GEORGE B. CALDWELL, '86, died at his home, Newbury, S. C., July 5, 1901.

DR. E. C. STEWART, '87, of Pittsburgh, is in Baltimore doing post-graduate work.

A CARD.

At the beginning of another season, we beg physicians to consider the advisability of sending more of their patients to us for prescriptions and sick-room supplies. We will waive matters of ethics and base our claims for additional patronage upon the excellent character of our work, the better results secured through concentrated efforts and upon the advantages a comprehensive stock gives us.

MICROSCOPICAL AND
CLINICAL SUPPLIES.

HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

IN CYSTITIS

and all inflammatory conditions of the urinary tract, difficult and painful micturition, wetting of the bed and wherever a demulcent diuretic is indicated

LITHIATED SORGHUM COMP. IS AN INFALLIBLE REMEDY

as the testimony of thousands of physicians bears evidence. It has acted in many instances where other remedies have failed to alleviate the condition of the patient or cure the disease. It possesses a pleasant, palatable taste and produces no cumulative or other undesirable effects. Its value depends upon the formula

AND CONTAINS

R	Broomcorn Seed (<i>Sorghum Saccharatum</i>)	}	120 grains.
	Corn Silk		
	Saw Palmetto		
	Hydrangea		
	Lithium Benzo-Citrate		16 grains.
	in each fluid ounce.		

Literature and Samples gladly furnished on application.

SHARP & DOHME LABORATORIES,

BALTIMORE, MD.

General Offices, 41 John Street, New York, N. Y.

Western Branch, 221 Randolph Street, Chicago, Ill.

Southern Branch, 422 Gravier Street, New Orleans, La.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap has been used exclusively in this baby's bath from birth, and her perfect skin and luxuriant hair excite wonderful interest and admiration.

AS A NUTRIENT SOAP
FOR THE SKIN . . .

Resinol Soap

IS WITHOUT A
PARALLEL.

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.,
SYDNEY, N. S. W.
Agents for Australasia.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

EXTRACT FROM THE INTRODUCTORY ADDRESS:
SESSION OF 1901-2.

BY DR. W. F. LOCKWOOD.

I have been appointed by my colleagues to give the introductory lecture of the session which we are just beginning.

The selection, you will understand, is in conformity with a time-honored custom of the school which makes it practically compulsory that the junior members of the Faculty shall thus in turn assume the duty which this evening has been assigned to me.

The compulsion required in this instance has been of the mildest sort, not that the experience of two years in the class room has developed an eagerness for "lecturing," but because the occasion appeals to me strongly as one full of interest to instructor and student. It is from the point of view of the student that I prefer to talk with you, and the opportunity seems fit to refer briefly to several subjects, some of which have a common interest for us as students of medicine—and some a special interest as students of the College of Physicians and Surgeons.

Many of you have probably read and reflected on the line which appears as an inscription in Osler's practice—a short quotation from Hippocrates—"Experience is fallacious and judgment difficult." It

is plainly meant in its application to serve as a word of warning to those who contemplate the practice of medicine. It suggests that the study of medicine too, is beset with difficulties, and that the way is nowhere easy from start to finish. It may safely be taken to mean also that serious, continuous, painstaking work is required if a student of medicine is to do credit to himself and to his profession.

At the outset of his career, the beginning of his medical studies, it is more than likely that the average student has very vague ideas of what he is starting out to do. He may have tried some occupation, and found it distasteful or unprofitable and have decided with no substantial reason that he will try medicine. He may be prompted by the commercial instinct and have the idea of making the most money with the least capital, or his reasoning may be similar to that of the Irishman who "thought he would like to be a Bishop because 'it was such a nice clean business.'" On the face of it, a class made up of such material would not be promising, and still the interest and the enthusiasm which may be awakened by the contact with earnest men, fellow students and instructors, may supply many of the deficiencies of early training and controvert all calculations as to the future of individuals who have gone haphazard into the profession of medicine.

For example: Some years ago there was graduated in this city a man who since has achieved a most enviable position as a pathologist. His reputation in his special field is more than national. Those familiar with his history recall that he enjoyed only a common school education; that he was asked not to return to college at the end of a term because he spent his time fishing; that he tried successively the occupations of clerk, merchant, broker and farmer, only to confess failure, and that finally, when beginning the study of medicine, he threw himself into it with the greatest heartiness and enthusiasm. He early became interested in the scientific side of medicine, and, having a splendid constitution, indomitable industry and great natural ability, he was able to accomplish a phenomenal amount of work. He plunged into the study of histology, biology, and pathology with the greatest vigor and became successively laboratory instructor, assistant, associate in pathology, professor of pathology. Few men have

ever shown themselves so thoroughly imbued with the spirit of work and few have had a more stimulating effect upon their students.

With the changes that have occurred in the last decade in the methods of acquiring a medical education, there has come also gradually a change in the standard of requirements adopted both by the medical profession and by the public.

We will hear no more of a man's being given credit or preferment because he has "walked" a hospital. Simply "walking" will not do. He must, if he hopes to compete with the young medical man of the present time, improve every opportunity to examine and study cases for himself. He must be prepared to exhaust all the recognized methods of diagnosis and to discuss intelligently the professional questions which arise.

In the same way it will not do in these times for the head of the family to decide that the boy who is unfit for anything or who has already failed at everything must study medicine. The best of the lot will be none too good even if he has already proven himself costly as regards his preliminary education. The well-trained men are undoubtedly the members of our profession who create the active competition and who will ultimately secure the coveted rewards. There is no dependence to be placed, in the future, on any but the substantial qualities which go to make up the modern physician.

Let the student of medicine therefore not delude himself with the idea that there is a short cut to success or that a readily acquired facility in passing written examinations will serve him beyond the point of his graduation or the passing of a State Board. Let him rather at the start settle himself for a course of patient, systematic work—work which properly undertaken becomes not more irksome but of ever increasing interest—work in which the contact with earnest teachers furnishes constantly a stimulus and of which the field becomes constantly broader and more attractive.

Reference has been made to changes of method in teaching and studying medicine. We do not appreciate how radical in some respects these changes have been nor the rapidity with which they have come, unless our recollections serve us in recalling the old-time two-

year medical course. The changes amount to a revolution. Not so very long ago the qualifications for graduation consisted of an attendance upon two courses of lectures, each extending over a period of about five months, and the passing, of course, at their close of a pretty safe examination. The lectures of the second session were practically a repetition of those already listened to in the first year. The graduation feature had not been introduced. Clinical study was almost entirely limited to the general clinics, where the student was told what the lecturer elicited from his physical examination of the patient. The majority of a class saw and heard imperfectly, as a rule, at these public clinics and had no opportunity to see cases in the wards—much less to examine them from day to day. Such work as was done by the students in the dispensaries and much of the work they saw done there was calculated to give very crude ideas of the practice of medicine.

Until twenty years ago or possibly later, lecturers made reputations in proportion to the beauty of their diction and their powers of oratory. Far more importance was attached to the lecturer's style than to his knowledge of pathology or clinical medicine. As in all reformations, we are tending towards the other extreme, and bid fair to lay so much stress on what is called the practical side of medicine as to almost exclude systematic text-book study. The seductive attraction of bedside work, the growing fondness for so-called practical medicine readily persuades the student that text-book study is irksome, that didactic teaching is a relic of ancient times, and that the whole science and art of medicine and surgery are comprised in an easy familiarity with the common ailments and injuries and a handiness in dealing with them.

Now to speak more particularly of what lies before us—of matters which have a special interest for the students of the College of Physicians and Surgeons: A glance at the schedule of lectures shows that the arrangement of the student's work for the first and second years is intended to ground him as thoroughly as possible in the fundamental branches of the medical course. Much time is allotted to the study of anatomy, including histology, osteology and the gross anatomy taught in the dissecting room—to the study of physi-

ology and the allied subjects, physiological chemistry and pharmacology, to the study of chemistry, including work in the chemical laboratory, and to the study of pathology. To this last subject the student is formally introduced in his second year of training to find it of increasing importance, as his field of labor widens, and possessing a renewed interest for him as student, as hospital physician and as a practitioner of medicine or surgery. These cardinal branches furnish the basis of medical education and the thoroughness with which they are studied in the first and second years, gauges the solidity and stability of the superstructure to be added in the years which follow. The mind and hand and eye, are trained preparatory to securing the greatest benefit from the clinical and technical work encountered in the contact with ward patients, in the examination and treatment of dispensary patients, in the elaboration of the methods of physical diagnosis and in the unfolding of the wonders of the clinical laboratory.

A large portion of the third year is devoted to attendance on clinical lectures, to didactic lectures on special diseases, and to the methods of medical and surgical diagnosis.

The fourth year is almost entirely taken up with practical work in the fields of medicine, surgery and obstetrics.

The schedule, as arranged, is the result of a gradual process of evolution which began not many years ago, and which has replaced almost entirely the older methods of teaching and studying medicine. Every year of late has introduced changes in our curriculum, changes which the experience of teachers and students has suggested and which seem to offer advantages. There has been a notable extension from year to year of the provision made for students to come in contact with medical and surgical cases at the bedside. It is a move many paces forward in the direction of teaching clinical medicine, to divide the large classes into sections for ward work, and to bring the students into the hospital atmosphere. It is the difference between the real thing and the description of it as compared either with the general clinic or the didactic lecture. It offers the greatest incentive to work which can possibly be provided for pupil and instructor, and the result can be seen in the interest manifested by these smaller

classes and in some of the carefully prepared histories of cases which are handed in.

In carrying out this plan, the Faculty has had the aid of men well trained for their work and ready to give the time necessary for instruction of this character.

Leaving out the more remote question of his subsequent career in his profession, every student of our school should know that his candidacy for graduation, for class standing, and especially for hospital appointment, will of necessity be greatly influenced by the position he maintains in his ward class. If, after the third year has been passed and a brief course of ward work has been completed, a student finds himself listless and inattentive in the face of his clinical opportunities, it is safe to assume that he has made a mistake and a serious one in beginning the study of medicine. The time has arrived when he should realize that "studying medicine" is not a matter of three years or four, nor a matter simply of gaining a diploma or making a living. He should realize, by this time at least, that the work he has in hand calls for his best energies and that it should awaken in him the spirit of growing enthusiasm.

Another important change and a comparatively recent one in our school has been the development and extension of the laboratory service required of students. There is a limit, of course, to the amount of work of this kind which can be crowded into a curriculum already well filled with studies deemed essential to the medical course. It is not reasonable to expect that all the graduates of the College shall be expert in making blood counts or competent to give final opinions on bacteriological and pathological questions. The point is rather made that what is taught in the laboratories is gone over carefully by the instructor, and a sufficient insight given the student to enable him to apply the knowledge acquired in making the ordinary routine examinations which may be called for in the every-day practice of his profession. At the same time sufficient training in this line may be acquired by those who show a special aptitude to furnish a good foundation for supplementary post-graduate laboratory work.

GONORRHEA AS A SOCIAL PROBLEM.*

BY DR. W. L. CHAMPION, '91.

It can be stated without fear of successful contradiction that most of the diseased pelvic conditions of women and the untold suffering they have to endure are traceable to gonorrheal infection, and the blame can be laid in a large measure at the door of the medical profession.

In a report of the committee of the section of State Medicine of the American Medical Association, Humiston states: "Without classifying doubtful cases as gonorrhea, 90 per cent, at least, of pelvic inflammatory troubles are attributable to gonorrhea, the infection being usually of a mixed character—gonococcal with some one of the pyogenic micrococci;" and Joseph Price says: "That in over one thousand sections for pelvic suppuration, 90 per cent were traceable to gonorrheal infection, and that 90 per cent of these histories are reliable and clear." Czerny "regards it as impossible to tell"; and Boldt estimates from 5 to 6 per cent, admitting it as a guess. Ten per cent is the estimate of Skene, Robb, Eastman and Bovee; Wathen, "nearly all of the cases," and Mann, "nearly all of those who have not borne children." The estimate of Pozzi and Frederick is 75 per cent.

Naeggerath thirty-five years ago stated that a "vast proportion of the death-dealing diseases in women were due to gonorrhea which the husband had had years before." While he who makes a statement like this in regard to a disease that is accountable for so much human suffering, may be branded as an extremist, if we will reflect for a moment upon the highly infectious nature of gonorrhea, how lightly it is looked upon by the laity and many members of our profession, the number of gonorrheal patients still uncured that marry, the number that are dismissed by the physicians as cured, but time proves to the contrary—these patients being dismissed without an examination of the urethra for stricture, not even the urine for "clap-shreds" (the secretions, if any, should be obtained

* Read at meeting Medical Association of Georgia, Augusta, April, 1901.

from the urethra, prostate, and seminal vesicles and examined microscopically), we can form some idea as to the number of women necessarily infected. If it was possible to examine the urethra of the husband of every woman suffering with inflammatory conditions of the uterus and adnexa, in the great majority of cases the source of infection could be traced to the husband's urethra.

The effects of gonorrhea are more serious and permanent in the female, and when it has invaded the deep glandular structures, the tubes, ovaries, peritoneal cavity, it is a question whether it is ever cured. The number of cases of gonorrheal ophthalmia, the large per cent of the inmates of the blind asylums due to gonorrhea, the number of sterile marriages due to the disease, should alarm the laity and the profession more than an occasional epidemic of yellow fever, smallpox or bubonic plague.

Now, the question arises, is gonorrhea a curable disease?

All cases in the male can be cured if the patient will follow instructions and submit to necessary treatment, whether medical or surgical.

In the report of the committee from the American Medical Association referred to, it is stated by Lydston that gonorrhea is curable "in the majority of cases"; Chismore, Fuller, and Verhoogen, "in the great majority"; Andry, "if the physician attends to it diligently and the patient is willing to care for himself as required and for as long a time as is necessary"; Feleki, "only a small percentage must, in consequence of the uncertainty of the duration of their infectiousness, or in consequence of serious complications, be looked upon as incurable. I estimate this proportion as about 3 per cent." Fingen states that "all are curable." The question is frequently asked as to the curability of anterior and posterior urethritis. In any case of gonorrhea that has covered a period of two weeks the posterior urethra is involved; which can be demonstrated by washing out the anterior urethra and having the patient to urinate in a glass, when "clap-shreds" will be seen. So, practically, in every case of the disease, the posterior urethra is involved. In our opinion it is curable either in anterior or posterior urethra.

We can state to a patient he is cured when he has no untoward symptoms, such as too frequent urination, getting up at night to urinate, pains in the urethra or bladder; when the urethra is free from stricture; when the prostate is not sensitive or enlarged; when the seminal vesicles are normal; and when, after repeated examinations, the gonococcus is not found and the urine is free from pus cells. When we find a patient's urethra in the condition as described it will be safe for him to marry, and if he contemplates such a step at the time, not to wait three, six, or twelve months to determine whether he is well or not, because he will in the meantime, in all probability, contract the disease again.

Within the past two years it has been our rule to stain and examine the discharge from every urethra we have treated. Frequently patients present themselves for treatment when there are only "clapshreds" present. When such is the case, we centrifuge the urine, collect the sediment, stain and examine it for the gonococcus. If necessary, we throw a strong solution of silver nitrate into the urethra so as to produce some discharge for examination. We have 219 specimens stained, mounted with name and date, and whether acute or chronic, obtained from patients in private practice, and in 98 per cent of examinations made where discharge was collected from the meatus for examination, whether acute or chronic form that had persisted for years, the microscope showed the gonococcus present. In other words, when there is a discharge of pus from the urethra 98 per cent of the cases will prove to be infectious. Of the 219 specimens obtained, 43 were from married men living with their wives. Of the 43 married men 21 voluntarily stated that their wives were in bad health and were being treated for some female trouble. No statement was made by the other 22 or questions asked in regard to the health of their wives. It is a notorious fact that when a married man comes for treatment for gonorrhea, or any urethral trouble due to the disease, that he states his wife is an invalid and tries to excuse his sins on account of his wife's health being wrecked, which he alone is accountable for.

Something should be done to check the ravages of this disease,

which is more serious and far-reaching than any disease that affects womankind. Regular inspection and examination of inmates of houses of prostitution, as practiced in European countries, have been suggested; the examination by law of the candidates for matrimony has been advocated and other legal methods suggested, but I think it will be admitted that regulation by statute is impracticable.

The only feasible way to check the ravages of gonorrhea is through the medical profession. Any law instituted or put into practice will get into the hands of politicians, or incompetent men, who will use the office for self alone, and be an injury to the profession and the public generally. Good can be accomplished and results obtained by teachers in the medical schools indelibly impressing upon the minds of the men that will make up the profession of the future the serious nature of gonorrhea and its far-reaching evil consequences. Let each individual member of the profession take and feel enough interest in the gentler sex to see to it that every patient that we treat with gonorrhea has a urethra that is beyond a doubt free from gonococci before he is dismissed as cured or allowed to marry. It should be the duty of every man who undertakes to treat the disease to first impress upon the patient the importance of always having the care and attention of a competent physician, and not a druggist to tide him over a disease that has such serious consequences. The patient should always be impressed that so long as "clap-shreds" or pus can be found in the urine, that the urethra is still diseased, and in all probability infection is possible. It too frequently happens that men with a slight discharge from the urethra tell us they consider the discharge harmless, not knowing that the slight morning drop is teeming with thousands of gonococci.

As stated by König: "No doubt it will be always impossible to get rid of this disease entirely, but if it were generally known how serious may be the consequences, the number of infections would no doubt be much less. The education of the public in this respect is chiefly in the hands of the medical profession. Have we been doing our duty in this respect?"

Prudential Building.

UPON THE IMPORTANCE OF EARLY DIAGNOSIS OF
TUBERCULOSIS OF THE LARYNX.*

BY DR. FRANK DYER SANGER, '88.

MR. PRESIDENT AND GENTLEMEN:—If we were called upon to decide in what respect the discovery of the tubercle bacillus most benefits humanity, we would of course say by enabling us to practice intelligent prophylaxis. If we were asked to give an opinion as to what is the most important clinical deduction from the enormous accumulation of knowledge of tuberculosis which has followed the discovery of the tubercle bacillus, we would decide unhesitatingly that the most useful lesson is the value of early diagnosis, since the benefit which our patients derive from our advice or treatment is in direct proportion to the promptitude with which lesions of tubercular origin are discovered after making their appearance in any portion of the economy, particularly in the lung, I say particularly in the lung, because while there seems to be no good reason, anatomic, physiologic, or otherwise, why primary localization of tuberculosis in the larynx should not take place, undoubted instances must be rare, though a considerable number of cases have been reported by unquestioned authorities. Personally, I always feel skeptical regarding my chest examination in the presence of a seeming primary localization in the larynx, and hesitate to pronounce it such, if there is the slightest deviation from the normal in the chest.

One hears a great deal of talk about the recognition of a so-called pre-tubercular stage. We cannot, of course, sanction the idea of making a diagnosis of tuberculosis in such a stage, but it is undoubtedly true that a thorough inquiry into our patient's near and remote history and a judicious consideration of such predisponent factors to tuberculosis, as sudden or gradual loss of weight, disproportion between weight and height, digestive disturbances, anæmia, diminished capacity for work or exercise without fatigue, character of the pulse and so on, will lead us to make more careful physical examination in many instances, which will result in earlier diagnoses.

* Read at the July Meeting of the Baltimore County Medical Association, held at the Eudowood Sanitarium for Tuberculosis.

Because primary localization of tuberculosis in the larynx is not, to say the least, common, the man whose work is rather strictly limited to laryngology is not privileged to be the frequent *discoverer* of lesions. Occasionally, of course, cases come to him in whom the pulmonary lesion has not been made out, but in a large number of instances the lung involvement has been already recognized by the family physician. Unfortunately, it is sometimes the melancholy duty of the throat specialist to pronounce sentence upon the dying. Every once in a while a poor, emaciated individual comes to my consulting room for the last judgment of a specialist. Only a short time ago a young man came to me, a twenty-four hours' journey, to be told, not of course with such brutal brevity, but told, nevertheless, that he was dying. That man's physician might have spared him the expense; the bitter, killing, disappointment; the physical exhaustion, which no doubt shortened his life, entailed by that journey, at a time when he should have been quietly resting at home, preparatory to his journey to another world.

The throat specialist's function should not be to see how late it is possible to make a diagnosis, but to assist the general practitioner in making an early one, and to further serve the family doctor and his patient by attending to those matters both therapeutic and surgical, which demand the special manipulative skill of the laryngologist.

The symptoms, apart from those belonging to the general symptomatology of early tuberculosis, pointing to beginning involvement of the larynx, whether primary or secondary, are few. The one which is of greatest value, since it is first in making its appearance, is some modification of voice—a peculiar fickleness of voice so to speak. Characterized by a variation from slight huskiness through the different stages of hoarseness to complete aphonia. The peculiarity being that the individual may run the entire gamut of these changes in the course of a short conversation which also we might add is accompanied by voice tire. Of course, in all pathological conditions of the larynx, voice modification is a probable result, but in no condition is the voice so variable. Without dwelling further upon this symptom, we may put it down as first and foremost in importance.

Some change in sensibility usually occurs, not infrequently the patient complains of a tickling, or itching, or scratching sensation low down in the throat, but actual pain belongs to a later, rather than to a premonitory stage. It is most often associated with ulceration and is most annoying when exposed locations, like the edge of the epiglottis or the region of the arytenoids are involved, making the act of swallowing an exquisite torture and converting laryngeal into the most horrible of all forms of tuberculosis.

Cough is quite as apt to result from irritation below, as in the larynx itself. In any case it is well nigh impossible to determine the point of its origin. The same may be said of secretion. The tubercular larynx secretes little except in the stage of ulceration, when the discharge may become profuse, prior to that time any secretion coming from the larynx is usually in the form of small pellets.

Obviously we cannot depend upon a symptomatology so meagre for a diagnosis. Physical examination is necessary, and inspection must chiefly be relied upon. Probably no other single condition in the larynx presents such a diversity of picture, depending upon the size, situation, character and stage of the tubercles as does established tuberculosis. Still the ensemble is so characteristic that the condition is rarely mistaken by the experienced laryngologist. On the other hand, the detection of the condition in its incipency often tests the skill of the most expert, involving a fine appreciation of color and form.

The first physical manifestation of tuberculosis of the larynx is a lightening of color, varying from slight paleness to actual pallor, usually being general, though it may be localized. Let me cite an illustrative case.

A young woman came to consult me in June '98 regarding a slight hoarseness, which was simply annoying, and a seemingly trivial cough. I had known her previously, she was about nineteen years old, five feet eight inches in height and weighed 135 lbs. Her physique was magnificent, she had never been sick in her life, and there was no history to arouse suspicion, though I learned quite accidentally some time later that she had roomed during the previous year

in the seminary with a girl who had a cough. The only deviation from the normal which I was able to detect was slight paleness of the mucous membrane of her larynx. There was nothing diagnostic in her chest. The sputum examination was negative. I saw her again two months later and there was no improvement in her voice or cough. She had accepted a position to teach and I was unable to dissuade her. Later in the autumn she had undoubted signs in her lung, but would not give up her work. By the end of the session in June she was a complete wreck and took to her bed; she died the following November.

Rarely when tubercular involvement of the larynx is very acute there is a stage of heightened color. Such cases are not so easily recognized. A young man came into our clinic a short time ago complaining of hoarseness and cough of a few weeks standing, he gave a history of syphilis. He was somewhat below par, his larynx was abnormally red. It was thought that the larynged condition might be due to syphilis and he was put upon anti-syphilitic treatment. The laryngitis did not, however, improve, but grew rapidly worse. His left apex was slightly suspicious, but no tubercle bacilli were found in his sputum at first. The physical signs in his apex rapidly became more pronounced, however, bacilli were found, and when last I examined his larynx a few days ago it was much paler and there was decided infiltration about the vocal process in the left cord. The patient is going to pieces very rapidly.

Local congestion in the larynx, particularly congestion of one cord, raises the question of syphilis, or tuberculosis, more especially the former. If this is the only appearance we must in most instances depend upon iodide of potassium for a diagnosis, which can usually be made in a week or ten days. While some change in color is usually the first physical appearance to be made out in the larynx, the most constant characteristic is some alteration in form. The character of the alteration depends upon the situation, number, size and stage of the development of the tubercle. Perhaps the commonest picture is that of infiltration and the commonest situation is the inter-arytenoid space. The pale, pear-shaped greatly œdematous

swelling of the aryepiglottic folds is very common, as is also the pale, thick epiglottis. Occasionally the individual tubercle can be seen—small, gray elevations just beneath the mucous membrane. When tubercles are heaped up—massed—sooner or later breaking down takes place, followed by superficial irregular ulcers, the margins of which are not usually elevated and do not present the boundary zone of passive hyperæmia. Something should, of course, be said regarding the value of sputum examination in laryngeal tuberculosis. If the tuberculosis is primary in the larynx, bacilli will hardly be found sufficiently early to be of great diagnostic value. If the process is secondary to pulmonary tuberculosis, sputum examination is of the same value as in lung tuberculosis generally, *i. e.*, while finding the bacillus is positive, not finding it is not positive negation. The laboratory diagnosis of tuberculosis should not in any sense supplant physical examination, but should be looked upon as a valuable accession to our investigation.

Regarding the diagnostic value of tuberculin, I cannot speak from personal experience.

I need not tax you further this afternoon with additions to the picture. These few points regarding color and form are the ones with which we must be familiar in order that we may recognize tuberculosis of the larynx in its incipency.

The later stages of tubercular laryngitis are less interesting and of comparatively little value from a diagnostic standpoint. It is true that we can do much to palliate the established tubercular condition. We are enabled by more recent therapeutic and surgical measures to rob the disease of many of its horrors. We even sometimes hear of such a thing as a healed laryngeal tuberculosis, but I should like to return to my before stated proposition that the earlier we make our diagnosis, the greater will be our usefulness to our patients. While primary localization may, no doubt does, take place, the number of cases must be extremely small as compared with primary localization elsewhere, more especially in the lung.

Gratifying as it may be therefore, to be able to appreciate the first indication of laryngeal involvement, our opportunities do not compare

with yours, and while we gladly give you the limited assistance which is within our power, we cannot but envy, you, who with eyes trained to detect slight alterations in the contour and movement of the chest, changes in the countenance and so on; finger tips educated to know beginning enlargement of glands—sensitive to alterations in formatus and ears cultivated to appreciate the finer shades of pitch and variation in tone, are able to locate this most to be dreaded of all foes almost at the moment of invasion of the economy, and thus to perform the greatest possible service to the human family.

525 N. Charles St.

GAUZE DRAINAGE IN INFECTION OF THE PUERPERAL UTERUS.

BY DR. WILLIAM S. GARDNER, '85.

The application of general surgical principles to the treatment of infections during the puerperal period is becoming firmly established. The prompt opening and drainage of areas of infection within the pelvis and the drainage of the infected uterus cannot be too strongly insisted upon. At least three methods have been used for the drainage of the infected uterus. Continuous irrigation; rubber drainage tubes and gauze packs have all been used. Continuous irrigation is troublesome, both to the patient and attendants, and the results from it have not been, in my experience, as good as was expected from it. The rubber drainage tube is fairly efficient, but is easily clogged up and, unless frequently cleansed, is useless. In a paper written in 1888, I gave in detail the method then employed to promote drainage by irrigation and the use of the rubber tube used both as a short tube as in ordinary drainage, and by the syphon action of the long tube.

Recently I have seen four cases in consultation, in which gauze was used. These cases all were more comfortable and recovered more promptly than where permanent irrigation or tubes were employed. These cases must not be confused with that class where there are retained decomposing Secundines, in which all that is neces-

sary is to empty the uterus and douche it out once to effect a cure, nor with those other cases in which the infection has invaded the structures beyond the uterus. Each of the four cases was undoubtedly a streptococcus infection involving the endometrium, but extending to sufficient depth to render intrauterine douching of only transient value.

CASE I.—The patient was a primapara and was confined on the afternoon of the day before I saw her, but the placenta had not been removed. There was evident infection at this time, and after the placenta was removed, the attending physician gave a thorough vaginal and intratuterie douche. Nevertheless, when I was called again to see her two days later, there was a marked rise of temperature and pulse, some tenderness of the uterus, but no indication of infection beyond the uterus. There was no odor, but from the uterus there came a sticky purulent discharge and the lips of the cervix were covered with a semi-membranous coating, which has given rise to the term "uterine diphtheria," but which is known to be due to a local streptococcus infection. With the curette considerable masses of this membranous deposit were removed. The uterus was then thoroughly flushed out with a large volume of 1-5000 bichloride solution, followed by sterile water. The patient improved, but only temporarily. The cleansing of the uterus was repeated and the cavity packed loosely with a weak iodoform gauze. The patient rested comfortably, the temperature and pulse improved. The gauze had to be renewed and replaced several times, but there was practically uninterrupted improvement from the time it was employed.

CASE II.—This patient had been confined about one week before I was called to see her. She had had some fever for several days. The uterus had not undergone involution as rapidly as normal and was tender on pressure. There was no evidence of infection beyond the uterus. A purulent discharge issued from the uterus. From the uterine cavity quite large masses of cheesy, semi-membranous material and small blood clots were removed with the curette. There was no retained placental tissue nor decidua. The uterus was packed with iodoform gauze. I did not see her again, but her attending phy-

sician stated to me that she never had an unfavorable symptom after the gauze drain was put in.

CASE III.—This patient had been attended by a midwife and was confined ten days before I saw her. She had been seriously ill some days and a physician had been called in. He had called a consultant who diagnosed a pelvic abscess and advised removal to a hospital for operation. The temperature and pulse were both high. The uterus was large and tender, but I was not able to make out any infection outside of it. Under anesthesia the uterus was curetted and semi-membranous masses were removed. The cavity was packed with gauze wrung out of a 1-5000 bichloride solution. This treatment was continued by the attending physician and the patient made a complete recovery.

CASE IV.—This patient had had a criminal abortion performed at an early period of pregnancy. When I saw her at the City Hospital she had marked septic symptoms; temperature high; pulse rapid, and pain and tenderness in the pelvis. Under anesthesia the uterus was found to be only a little above the normal non-pregnant size and perfectly movable. The curette removed some small cheesy masses, but nothing else. The cavity was packed with iodoform gauze. The temperature and pulse dropped to normal at once and remained there the three days that the gauze was allowed to remain in place. After its removal the temperature rose again and a small strip of gauze was replaced. The temperature fell at once and remained down.

It has been urged upon theoretical grounds that the use of the curette in cases of infected uterus only served to open up new avenues for infection. The practical advantages of removing any debris and thoroughly emptying the uterine cavity far outweigh any theoretical objections, and I have never known any bad results from it.

The gauze can be introduced most easily by exposing the cervix with a speculum, inserting a tenaculum into one lip of the cervix and then pushing up with long dressing forceps to the fundus as wide a strip of gauze as will pass through the cervical canal. Packing the cervix too tightly must be avoided, but a very narrow strip of gauze will not give sufficient drainage. The much advertised gauze packers have been perfectly useless to me in these cases.

ACUTE DILATATION OF THE STOMACH.

BY DR. JULIUS FRIEDENWALD, '90.

We are greatly indebted to Kussmaul who first pointed out many interesting conditions associated with gastric dilatation. The symptoms of this disease are now so clearly established that the diagnosis can usually be made without difficulty. From an etiologic point of view two forms of dilatation of the stomach may be distinguished, the acute and chronic varieties. While the most frequent cause of chronic dilatation is stricture of the pylorus, the acute form is usually due to a sudden paralysis of the gastric muscles.

Much attention has been paid to chronic dilatation, while little has been said concerning the acute form, which is probably due to the fact that it occurs with much less frequency. It is true that many allusions are made in literature to conditions of gastric dilatation following serious infectious diseases, such as typhoid fever, cholera, puerperal fever, etc., but these conditions are purely cases of extreme gastric atony, with which dilatation is often confused. Thus Bamberger, as far back as 1855, calls attention to the fact that serious infectious diseases are apt to produce acute gastric dilatation. Boas recognizes two varieties of acute dilatation of the stomach. First, dilatation due to sudden overloading of the stomach or some gross error in diet (*dilatatio ab ingestis*). Second, dilatation due to paralysis of the muscles of the stomach of central origin. This condition is usually secondary to some other serious disease, such as typhoid fever, scarlet fever, etc. Cases of the first variety have been reported by Hilton Fagge, Tyson, Boas, Fraenkel, Nauwerk and Broadbent.

Two cases of acute dilatation of the stomach have come under my care. Both belong to the first variety.

The first patient, J. P., male, age 34 years, first consulted me January 11, 1899. He had always been healthy; he never had had any serious illnesses nor any gastric disturbances; before this present attack he could digest all varieties of foods, even the most indigestible ones, with great ease, and would never have any discomfort therefrom. The patient was taken suddenly ill on the morning of January

10, 1899, after having eaten lobster salad the previous night. He complained then of intense pain in the abdomen, in the region of the stomach, eructations, distension, headache, thirst and fever. Four hours after the attack first began, a physician was called in, who administered a hypodermic injection of morphia; he was very slightly relieved, but in a few hours the pain and nausea became more intense, and diarrhea set in, but no vomiting. About 9 P. M. the same evening another morphia injection was administered, and some simple mixture of bismuth was given internally. The pain and nausea were relieved for some hours, but again returned with great intensity. Diarrhea now became intense; within the next six hours the patient had ten movements.

At noon the following day I was first called to see this patient. He had vomited for the first time two hours before I came; he, himself, had noted the fact that the quantity vomited was by far greater than what he had ingested during the past day; it was very acid and contained much undigested food.

On examination the patient was found to be a very strongly-built individual, with good muscles; tongue much coated; pulse strong—110 beats to the minute; temperature, 101° F. Urine scant and high-colored; it contained large quantities of uric acid; no albumin; no sugar.

The abdomen was much distended in the region of the stomach, which could be mapped out as if it had been artificially inflated with gas; on percussion the stomach was found to reach two fingers' breadth below the umbilicus. Peristaltic movements were not visible. In order to relieve the patient of intense pain, nausea and distension as quickly as possible, it was determined to practice lavage; before the tube could be gotten the patient had again vomited a very large quantity of a greenish fluid containing undigested food remains. The stomach tube was now introduced; a large quantity of gas was at first expelled, followed by a mass of greenish fluid. The stomach was then washed; although two quarts of water were utilized for the purpose, the wash-water did not appear clear. The tube was, however, removed, as the patient seemed much exhausted. The examina-

tion of the contents of the stomach, at first removed through the tube, revealed 500 cc. of a dark green liquid containing many food remains. The acidity was 85; free hydrochloric acid, 0.28 per cent; no sarcinae.

The patient was placed upon a diet of broth and milk, a tablespoonful of each alternately every two hours. The nausea and distension were relieved for three hours, but then returned with great intensity, and the patient again vomited at 10 P. M. a large quantity of green fluid with masses of food remains. He partook of no nourishment during the entire night, and only small bits of crushed ice occasionally. The temperature was normal on the following morning, but the nausea and pain continued. The tube was again introduced, when 300 cc. of contents with undigested food were removed. The stomach was washed thoroughly with two quarts of water.

The examination of the contents removed showed a total acidity of 80; HCl free = 0.21 per cent, no sarcinas. The patient felt much improved; the pain and distension were greatly relieved; the bowels, which had not been evacuated for three days, were relieved by an enema. The diet still consisted of broth and milk. Toward evening the patient again began to feel very uncomfortable; the abdomen continued distended and the nausea returned; lavage was again practiced. For the next two weeks the stomach was washed twice daily and the improvement was very marked. The patient was able to take fair quantities of liquid nourishment, and only toward evening and early in the morning before lavage did the nausea and distension become unbearable. The stomach was always found to contain large quantities of contents, even though the patient had not had nourishment for fourteen hours before lavage; on the morning of January 20 a test breakfast was given, consisting of 300 cc. of water and 35 grams of bread; one hour afterward 400 cc. of contents were removed, containing curds from the preceding day's milk. The total acidity was 100; free hydrochloric acid, 0.27 per cent; no sarcinas.

From now on lavage was practiced once daily (in the morning) and small quantities of digestible solid food were allowed; the improvement continued, though whenever lavage was neglected, considerable quantities containing food remains of the preceding day's meals, would be vomited.

On March 3, after having omitted lavage for three days, the stomach was expressed of its contents in the morning before breakfast, when 300 cc. of fluid were removed, the total acidity of which was 80; HCl free = 0.24 per cent. Sarcinas were present in abundance. The stomach was washed and a test breakfast given. The examination of the contents showed a total acidity of 90; HCl free = 0.25 per cent. On inflation the greater curvature of the stomach was found to reach four fingers' breadth below the umbilicus.

Similar results were obtained April 12, May 14 and September 9, 1899, when the patient was seen for the last time.

There can be no question as to the correctness of the diagnosis of acute dilatation in this case.

The second case is that of a girl, S. R., 14 years of age. She had always been robust and well and had never complained of any digestive disturbance. Five hours after eating sausage at noon of November 29, 1900, she suddenly began to complain of eructations, distension, nausea and pain in the abdomen. The pain was somewhat relieved by the use of paregoric and hot applications, but the distension became more marked. There appeared a slight rise of temperature. This condition continued for three days with more or less temporary relief, occasioned by the frequent use of paregoric. During all this time the patient partook only of small quantities of milk. At 8 A. M., December 2, after extreme nausea during the whole night she first began to vomit a very large quantity of very green acid material containing masses of milk curds and also food remains. The vomited matter had the odor of tainted sausage and contained a number of raisins eaten the same day and several hours before the sausage. Constipation, which had existed all this time, now gave place to intense diarrhea. I was consulted at this stage and found the patient, who had apparently been a very robust girl, in almost a state of collapse; pulse, weak, 130; temperature, 103°; respiration, 34.

The abdomen was intensely distended over the region of the stomach as if it were artificially inflated, and in this area was very tender to pressure. Peristaltic movements were not visible. On percussion

the stomach was found to reach three fingers' breadth below the umbilicus. The stomach tube was at once introduced and a very large quantity of fermented material as well as gas gushed forth through the tube. The stomach was at once washed; the contents at first removed through the tube was placed aside for examination. It consisted of 300 cc. of a greenish fluid containing much undigested food remains, in which the skin of sausage, as well as raisins could be detected; on standing, the three-layered contents so characteristic of dilatation was formed.

The total acidity was 80; free hydrochloric acid=0.21 per cent; sarcinas in abundance. The patient was placed upon tablespoonful doses of milk and broth alternately every two hours; after lavage she felt much easier; the distension and pain disappeared. On the same evening the stomach was again washed, when 100 cc. of contents, with much the same appearance as that removed in the morning, was obtained. The temperature fell to 110° ; pulse, 100 and stronger; respiration to 28; the diarrhea was less intense.

December 3, 8 A. M., 50 cc. of contents removed from fasting stomach; total acidity, 82; free HCl=0.22 per cent; no sarcinas; temperature, 98.6° ; pulse, 80; respiration, 20; distension and tenderness much less marked; no nausea; patient comfortable; general condition good, lavage practiced.

December 4, 8.15 A. M., 80 cc. of contents removed from the stomach; total acidity, 84; HCl free=0.25 per cent; no sarcinas; lavage.

Daily lavage was practiced; the results were uniform; on December 7, patient was permitted to take small quantities of solid food, which she bore without discomfort. On the morning of December 10 the stomach was expressed of its contents before breakfast; 300 cc. of fluid was removed; total acidity, 85; HCl free=0.25 per cent; no sarcinas; much undigested food remained.

December 12, contents of stomach removed after an Ewald test breakfast; 500 cc. removed containing meat particles eaten day before; total acidity, 100; HCl free=0.27 per cent; no sarcinas. Tests were made of the stomach at intervals of four to five days until Feb-

ruary 4, 1901; at all times food particles could be detected in the contents of the stomach in the morning before any food had been taken. The gastric total acidity was always high (80 to 100) and there was an excess of free hydrochloric acid.

The patient was forced to be careful with her diet, otherwise vomiting would be occasioned, notwithstanding the daily lavage.

There can be no question but that the acute dilatation in this case took its origin in an attack of acute dyspepsia.

The etiology of acute dilatation is somewhat obscure. There can be no question but that it may take its origin in a certain class of cases from some gross error in diet or sudden overloading of the stomach; in another class from a sudden paralysis of the muscles of the stomach, due to the poisoning of the nerve centers. Pepper and Stengel suggest that the immediate cause in many cases is spasm of the pylorus, due to an irritation of the gastric contents. Kelling, who has made a number of examinations to determine the cause of postoperative dilatation of the stomach, found a passive valve-like closure arising from folds in the duodenum. He believes the absence of mobility may be caused to some degree by the anesthesia, and that gastroptosis is a predisposing cause of this condition.

There are certain symptoms characteristic of this trouble: These are the sudden and rapid distension of the stomach, the pain and the absence of peristaltic movements, the absence of vomiting and diarrhea in the early stage of the disease, followed by intense and constant vomiting of very large quantities of greenish fluid, accompanied by great exhaustion. It is probable, as Boas points out, that acute dilatation of the stomach does not occur more frequently, inasmuch as in most cases of acute indigestion, vomiting and diarrhea come on at once, and thus the fermented material is quickly gotten rid of; while in cases of acute dilatation, vomiting and diarrhea are only late manifestations. It is therefore well to remember the possibility of the occurrence of acute dilatation in all cases of acute dyspepsia, and thus to empty the stomach quickly, either by means of some brisk emetic or by means of the stomach tube, so as to avoid the accumulation of fermented material, which is apt to give rise to a sudden and perhaps a permanent distension of the stomach.

WILLIAM S. GARDNER, M. D., EDITOR,
1012 McCulloh Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER,
Postal Station No. 202.
Telephone, C. & P., Tuxedo, No. 303.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE COLLEGE.

The outlook for the session of 1901-2 is the most brilliant in the history of the College of Physicians and Surgeons. The class is larger than it has ever been since the introduction of the graded course. And the average man in the school is better qualified to undertake and carry through to completion a thorough course in medicine than has been the case previously. Each year sees an improvement in this respect.

The accession of Dr. William Royal Stokes to the Faculty as professor of pathology insures that the laboratory work in bacteriology and pathology will be second to none.

The Faculty has equipped the laboratories completely, and every facility and encouragement to do good work is offered. The laboratory courses in chemistry and histology the first year; in bacteriology, pathology and chemistry the second year, and the work in the clinical laboratory the third year, make the student familiar with all the modern methods in diagnosis. The clinical work that each student does in his fourth year makes him acquainted with the practical application of these methods and fits him to begin his work with an equipment far beyond anything that it was possible for the student to acquire anywhere in this country ten years ago.

The College of Physicians and Surgeons is not struggling to keep up with the times; it is pointing the way.

POST-GRADUATE COURSES.

The post-graduate courses which will be given in the spring of 1902 will begin promptly after the end of the regular session, and all the laboratories and all the clinical material will be at the disposal of the various instructors who have charge of the courses. This work has been arranged especially for our Alumni and, although no detailed announcement has been sent out, letters have already been received from a number who expect to be present the first session.

Personal Notes.

DR. E. R. PARK, '92, has located in York, Pa.

DR. E. M. VARNEY, '95, died recently at White Mills, Pa.

DR. A. W. RUSHMISLE, '98, has located at Lovettsville, Va.

DR. WM. J. TREFETHEN, '94, is practicing at Wilton, Maine.

DR. ROBERT G. BLACK, '86, has removed to Vancouver, Clarke Co., Washington.

DR. JAS. L. PERO, '91, died of tuberculosis at Indian Orchard, Mass., July 10, 1901.

DR. PHILIP B. CHANCELLOR, '01, has located at 1908 Sunderland Place, Washington, D. C.

DR. S. H. ALLEN, '90, of Provo, Utah, expects to spend the winter in Baltimore doing post-graduate work.

DR. WILLIAM J. TODD, '88, retires this month from the office of President of the Clinical Society of Maryland.

DR. HARRY FRIEDENWALD, '86, spent July and August in Europe. He attended the annual meeting of the Ophthalmological Society of Germany at Heidelberg and was elected to membership.

DR. DAYTON J. LONG, '97, is engaged in practice at Piedmont, W. Va. He brought a patient to the City Hospital the past month. The doctor was formerly resident physician at the Maternité.

DR. FRANK D. KINSLEY, '82, has removed to Denver, Col., and opened an office at 1427 Stout Street. He reports that Dr. James J. Powers, '81, is located in the same building and is doing a fine business.

DR. GUY E. BARKER, '87, is practicing at Bonner's Ferry, Idaho. He has recently had an interesting case of congenital absence of the uterus and appendages which he has promised to report in full in the near future.

DR. HENRY R. MCGRAW, '01, Denver, Col., writes: "I located here about two months ago and am doing fine. I am associated with one of the best men in the West, and am Demonstrator of Anatomy in the Gross Medical College."

DR. GEORGE LEWIS STALEY, '78, died at his residence, 1628 North Calvert Street, September 10, 1901. He was born at Mt. Washington, Baltimore Co., and after graduation practiced in Frederick County until 1884 when he located in Baltimore.

DR. JAMES H. FINCH, '95, of Champaign, Ill., stopped in Baltimore for a brief visit while on his summer vacation. He has an excellent practice, is secretary of the Twin City Medical Association, and medical examiner for several life insurance companies.

DR. J. RILEY MCCALLUM, '00, writes from St. Mary's, W. Va.: "I have been here for the past month and am doing first rate—have had two labor cases and other things in proportion. However, the other doctors of the town are still doing business at the old stand. Haven't driven any of them out of business yet."

DR. ALFRED T. GUNDRY, '94, DR. LEWIS H. GUNDRY, '90, and the Misses Gundry have opened a sanitarium for nervous and mild cases of mental disease on the Frederick Road, just beyond the city limits. The location is one of the most suitable that could be obtained anywhere. After Dr. Alfred Gundry graduated, he spent one year as resident physician at the Maternité and then went to Iowa, where for three years he was assistant physician in the State Hospital for Insane at Clarinda. There is every prospect that the new sanitarium, of which he is the active head, will be a great success.

DR. RALPH ERSKINE JOHNSON, '94, was killed by a patient in the State Hospital for Insane at Danville, Pa., April 3, 1901. Dr. Johnson was born January 1, 1867. He attended the district school near New Wilmington, Pa., and at the age of 22 graduated from Westminster College. He then spent some time as attendant at the Dixmont Hospital for Insane. He spent one year in Cleveland studying medicine and graduated from the College of Physicians and Surgeons in Baltimore in 1894. After a short term of service as resident physician at the City Hospital at Cumberland, Md., he resigned to accept the position as assistant physician at the State Hospital, Danville, Pa.

During the usual evening round the doctor was attacked by a patient and received four stab wounds. One about one and one-half inches below the clavicular notch, penetrated the sternum, pericardium and arch of the aorta. The hemorrhage into the pericardium caused death in about twenty minutes.

DR. JOHN RUHRÄH, of Baltimore, '94, has just returned from an eighteen months' trip abroad. While in Europe he followed up his special studies of internal medicine and diseases of children in the clinics of Vienna, Berlin, London and Paris. Dr. Ruhräh will have charge of the work in diseases of children at the College this year. He has opened an office at 839 North Eutaw Street. We append

excerpts from a letter received from him during the latter part of his trip which may prove of interest:

The question of where one shall study abroad is a difficult one and I cannot well answer your question as it involves so many personal points. These you must consider for yourself, but I may be able to help you on some of the others.

In the first place it is a question of country, and I had personally so much trouble trying to decide which one was the most desirable that I decided to try four and see what I could get out of them. Leaving out the question of surgery and the like and confining ourselves to medical work, I can unhesitatingly say with Grant Allen, "Young man, go to Europe." Like him, too, I may add, spend the smallest portion of your time in England. It is more like America in many ways than the other countries and consequently is less interesting and less instructive. A month or two in London will repay, no doubt, and, of course, very largely when one takes into consideration the language. There is the famous Hunterian Museum with its wonderful treasures, so fully described in its masterly catalogue, and one cannot well afford to miss it. Then the hospitals are large and inviting, and, if one goes well introduced, the men are most courteous and attentive. The out-door clinics are very large, almost too large for thorough work. But here one meets with a certain drawback. The Englishman is not a born teacher like the German or the German-Austrian, and does not delight in pointing out the things about the cases, so that one is left very much to his own devices and can pick up what he can. There are exceptions to this, it is true, but it is a general rule.

But, after all, there is not so much difference in methods, and one does not notice much difference from American clinics, except that every one is interested in heart disease and everyone uses the ophthalmoscope in medical cases. All the internes in the hospital run about with them like they would with a stethoscope.

If one speaks a little French and has good habits of work, Paris is a most attractive city for medical study. The same thing applies to the Frenchman as to the Englishman. He is not a born teacher, and

while you may glean a great deal from a clinic or a ward class, in fact, a very great deal, without much labor on your part, still the knowledge is not crammed down your throat like it is in Germany. If one has covered the elements of his work pretty well, so that he can get along by himself and profit by rather advanced work, then Paris is a delight, for no where in the world can one see as many cases together. The hospitals are devoted to certain subjects in a general way, and when one goes down to a hospital, where they have nervous cases, for example, he will see ward after ward of nothing but nervous cases. I saw more rare and interesting things in Paris than anywhere else, and the courtesy of the Frenchman I found delightful. Paris holds other delights not medical but none the less enjoyable. But you know the delights of it, so there is no need to expatiate on the charms of a few months in Paris, else I may not end this letter in time for the next boat.

There remains Austria and Germany. If we limit it to Vienna and Germany it will be easier, as the smaller Austrian Universities are not much frequented by Americans, although one can find good work in them.

Having decided to go to Germany, or Austria, which is much the same, as they speak German at the places where you would wish to go, it is necessary to make up your mind whether you will go to one of the larger cities or one of the small university towns. If you want to learn German or to do laboratory work without the interruptions of a great city, by all means settle down at any of the smaller towns according to your preference, but if you want to profit by the opportunities afforded in opera, concerts, and theatre, by all means go to one of the cities. Personally, I don't believe you will regret it. I only know Vienna and Berlin well, but I am told that Munich is a very satisfactory place to study. The town itself is certainly charming. In the larger places you will have large clinics and plenty of autopsy work and contact with the greatest medical lights of the country, notwithstanding the fact that even the smaller places boast of celebrated men. There are more of them in the great cities, and you can take your pick after hearing all of them. Whether you go

to Vienna or Berlin depends largely on what you want to study. Both places have advantages. In Vienna everything is central and you save time. But you won't go far wrong whichever one you pick out. The German loves to teach, and you will see what dogged perseverance and thoroughness can accomplish in the face of rather great difficulties. And then, too, you brush up your German and that is worth a great deal to the medical student.

HUBBARD, IA., July 22, 1901.

WM. S. GARDNER.

Dear Doctor:—Enclosed please find \$1.00 in payment for THE JOURNAL. Always affords me great pleasure to read it through and learn of the whereabouts and doings of the Class of '84 and '85 as well as the others. I, like a great many of the graduates of the P. and S., have been negligent in keeping in as close touch with our professors and the school as we should, and in so doing lose many an opportunity to benefit both them as well as ourselves. I see by the July number there is to be a post-graduate course in the spring of 1902. This is a much-needed step and one that should have been taken before. I have taken three courses of sixteen, eight and six weeks at Philadelphia Polyclinic, New York and Chicago since 1885, and, if possible, will spend some time in Baltimore in 1902. Have been devoting my time and energies along the line of surgery and eye, ear, nose and throat. Have a nice practice in those mentioned as well as a general practice. Wishing you continued success in your undertaking, I am

Very respectfully,

J. FRANCIS R. BRUBAKER, '85.

Book Notice.

MANUAL OF CHEMISTRY.—A guide to lectures and laboratory work for beginners in chemistry. A text-book specially adapted for students of medicine, pharmacy and dentistry. By W. Simon, Ph. D., M. D. Seventh edition, octavo, pp. 613, with sixty-six illustrations, one colored spectra plate and eight colored plates, representing sixty-four chemical reactions. (Lea Brothers & Co., Philadelphia and New York, 1901.)

The alumni who for the past seventeen years have used this manual will be pleased to know that while the first edition was considered a model text-book it has improved with each new edition until now this seventh comes to us with more additional matter and greater improvements than any previous edition and detailing in the most concise and clear English the latest and most useful facts in chemistry. To every one who has been under the spell of the enthusiasm of its ever youthful and genial author it will bear a personal message.

To those who have spent two years in daily study of a book it is hardly necessary to go into a detailed description of its general construction and divisions. Only an outline of some of the additions will be noted.

The entire section devoted to chemical physics is admirable. The clear, clean-cut way in which these general principles are stated leaves nothing to be desired. Among other good things the explanation of polarization and the description of the polariscope are particularly striking and will be appreciated by all who have attempted to describe the workings of this instrument to a class of students.

The chapter on proteins has been entirely rewritten and contains the latest trustworthy information concerning the properties of this highly important group of compounds. The classification of the numbers of this group has the advantage of clearness and simplicity.

The section on physiological chemistry shows many alterations. A number of experiments have been added. A chapter on digestion has replaced the paragraphs on that subject. The discussion of foods and food values has been extended.

The portion of the book that will appeal most strongly to the practitioner is that which deals with the clinical examinations of the gastric juice, feces and urine. These tests are so arranged that they can be carried out by any one with a very modest laboratory and a moderate knowledge of chemistry.

PREVENTS & CURES DIPHTHERIA

Use our
Antidiphtheritic Serum
in all exposed cases.

*It prevents as well as cures
Diphtheria.*

*We have reports from 74
eminent physicians of
2197 cases of diphtheria
treated with our Anti-
diphtheritic Serum, with
only 51 deaths - a mortal-
ity of only 2.32%. No other
serum ever yielded such
high percentages of recovery.
Why not always specify
P.D.&Co. and get the best?*

PARKE, DAVIS & CO.

HOME OFFICES AND LABORATORIES, DETROIT, MICH.

BRANCHES IN NEW YORK, KANSAS CITY, BALTIMORE,

NEW ORLEANS, CHICAGO, LONDON, ENG., MONTREAL, QUE.

BRANCH LABORATORIES, HOUNSLOW, ENG., WALKERVILLE, ONT.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, N. Y., Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S. Ohio.
E. PARMLY BROWN, D. D. S. N. Y.
A. L. NORTROP, D. D. S. N. Y.
E. L. HUNTER, D. D. S. N. C.
W. W. WALKER, D. D. S. N. Y.
OSCAR ADELBURG, D. D. S. N. J.
G. MARSHALL SMITH, D. D. S. Md.
C. M. GINGRICH, D. D. S., Resident. Md.
J. HALL MOORE, D. D. S. Va.

R. B. DONALDSON, D. D. S. D. C.
H. A. PARR, D. D. S. N. Y.
J. EMORY SCOTT, D. D. S. Md.
C. L. ALEXANDER, D. D. S. N. C.
M. M. MAINE, D. D. S. Conn.
J. W. DAVID, D. D. S. Texas.
A. C. BREWER, D. D. S. Md.
J. ROACH, D. D. S. Md.

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

W. W. DUNBRACCO, D. D. S. J. K. BURGESS, D. D. S. J. C. SUTHERLAND, D. D. S.
GEO. V. MILHOLLAND, D. D. S. CHAS. THEBERATH, D. D. S.
L. M. PARSONS, D. D. S. HARRY E. KELSEY, D. D. S. C. H. CARSON, D. D. S.
H. M. LEVER, D. D. S. C. S. GORE, D. D. S. L. F. PALMER, D. D. S.
C. R. STEWART, D. D. S. L. D. CORIELL, D. D. S.
H. H. HAYDEN, M. D., Demonstrator of Anatomy.
C. F. BLAKE, M. D., Demonstrator of Anatomy.

The Sixty-First Annual Session will commence on the 1st of October, 1900, and continue until May, 1901.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.

ANNOUNCEMENT
OF
POST-GRADUATE COURSES
FOR
PRACTITIONERS OF MEDICINE

Beginning April 28th, 1902, and continuing for six weeks. These embrace courses in *Medicine* (including daily visits to the medical wards), *Pediatrics* and *Nervous Diseases*, *Surgery* (general, orthopedic, genito-urinary surgery and cystoscopy), *Gynecology*, *Operative Obstetrics*, *Ophthalmology* (including a course in the use of the Ophthalmoscope), *Otology*, *Laryngology*, *Pathology* (Demonstrations of fresh specimens and microscopic course), *Bacteriology* and *Clinical Laboratory* courses in the microscopic and chemical examination of the blood, urine, gastric juice, fæces, etc., etc.

These courses *are entirely* practical.

A certificate of attendance will be given at the end of the course.

For schedule and further information apply to

DR. HARRY FRIEDENWALD, CHAIRMAN,

College of Physicians and Surgeons,

BALTIMORE, MD.

College of Physicians and Surgeons OF BALTIMORE.

— FACULTY —

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- AARON FRIEDENWALD, M. D.,
Professor of Diseases of the Eye and Ear.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Pathology and Medical Jurisprudence.
- C. HAMPSON JONES, M.B., C.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, M. D.,
Professor of Obstetrics.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- W. F. SMITH, A. B., M. D.,
Associate Professor of Surgical Anatomy.
- B. HOLLY SMITH, M. D., D. D. S.,
Professor of Principles and Practice of Dental Surgery as applied to Medicine.
- HARRY FRIEDENWALD, A. B., M. D.,
Associate Professor of Diseases of the Eye and Ear.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MOCLEARY, M. D.,
Associate Professor of Physiology and Demonstrator of Histology and Pathology.
- CHARLES E. BRACK, M. D.,
Associate Professor of Obstetrics and Lecturer on Pharmacy.
- JOHN RUHRÄH, M. D.,
Associate Professor of Diseases of Children and Demonstrator of Pathology.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy and Demonstrator of Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Assistant Demonstrator of Anatomy.
- SYLVAN H. LIKES, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MOGLANNAN, M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- ALBERTUS COTTON, M. D.,
Demonstrator of Surgery and Assistant Demonstrator of Anatomy.
- GLENN M. LITSINGER, M. D.,
Demonstrator of Obstetrics.
- M. EKSTRÖMER, M. D.,
Demonstrator of Chemistry.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- SYLVAN ROSENHEIM, M. D.,
Demonstrator of Bacteriology.
- ARCHIBALD C. HARRISON, M. D.,
Assistant Demonstrator of Anatomy.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Clinical Assistant in Gynecology.
- W. B. WOLF, M. D.,
Demonstrator in Clinical Laboratory.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- S. S. HOULTON, M. D.,
Assistant in Diseases of Stomach.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternity Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Table of Contents Page III.

Issued Quarterly

Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS
BALTIMORE.

Vol. IV

No. 4

JANUARY, 1902

PUBLISHED AT
Baltimore and Eutaw Sts. Baltimore, Md.

GIVES BEST RESULTS



MULFORD'S ANTITOXIN

PHILADELPHIA, CHICAGO

H. K. MULFORD
COMPANY
CHEMISTS

Mulford's Glycerinized Vaccine

is prepared with every possible aseptic precaution. Each separate yield is subjected to the most rigid tests. It is guaranteed to succeed in 100 per cent. of primary cases, and retains its activity at least six months.

The virus from absolutely healthy animals only is employed, and each separate yield is subjected to the most rigid Physiologic and Bacteriologic tests.

H. K. MULFORD CO.

Chemists

PHILADELPHIA

CHICAGO

Case of 10 tubes—10 vaccinations—\$1.00. Mailed upon receipt of price. Write for literature.

The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS.

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,

CATONSVILLE, MD.

REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
Memoir of Prof. Edward Lloyd Howard, M. D. DR. THOMAS S. LATIMER,	97
Heredity in Diabetes Mellitus, with a Report of Six Cases Occurring in a Family. DR. J. HALL PLEASANTS,	105
Meningocele. FRANCIS P. O'NEAL,	113
A Case of Meningocele. DR. L. J. OWEN,	117
Editorial,	121
Personal Notes,	127
Correspondence,	128

**"OUR
LEADER."**

Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.

All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,

BENJ. A. NELSON, General Manager,

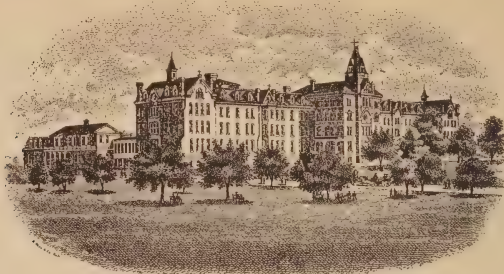
MANUFACTURERS AND IMPORTERS,

300 N. HOWARD STREET,

BALTIMORE, MD.

PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES,

ST. AGNES' SANITARIUM.



This Institution is beautifully situated on high, rolling ground, just outside Baltimore, and overlooking the Bay. It is thoroughly equipped as a modern Sanitarium for the treatment of Nervous Diseases and Drug Habits (no mental cases received). A complete Hydrotherapeutic Establishment has been recently added. Electric outfit, Gymnasium, Massage by trained operators, Sun Parlors, Billiard Rooms, Tennis, Golf, &c.

Medical Director, George J. Preston, M. D., Professor of Nervous Diseases, College of Physicians and Surgeons, Baltimore.

For further information, terms, &c., address

THE SISTER SUPERIOR,

St. Agnes' Sanitarium, Carroll P. O., Baltimore, Md.

CLINICAL LABORATORY OF Dr. CHARLES E. SIMON.

Private instruction in Clinical Chemistry and Microscopy; in Normal and Pathological Histology. Facilities for original work.

Examinations of blood, urine, stomach contents, feces, tumor specimens, etc.

Chemical and bacteriological examination of drinking water, milk, etc.

1302 MADISON AVE., BALTIMORE, MD.

A CARD.

At the beginning of another season, we beg physicians to consider the advisability of sending more of their patients to us for prescriptions and sick-room supplies. We will waive matters of ethics and base our claims for additional patronage upon the excellent character of our work, the better results secured through concentrated efforts and upon the advantages a comprehensive stock gives us.

MICROSCOPICAL AND
CLINICAL SUPPLIES.

HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

S. & D.'S HYPODERMIC TABLETS

were the first porous, and hence quickly soluble hypodermic tablets offered to the medical profession. Their high standard of excellence in solubility, uniformity and reliability has been maintained uninterruptedly since their inception. They have been frequently known as cold water tablets, because they dissolve faster in cold water than most others do in warm water, and it is generally admitted that they

ARE THE MOST SOLUBLE

hypodermic tablets offered the medical profession to-day. No watch is necessary to time their rate of solubility, as is the case with other makes, for they dissolve instantaneously. Merely drop a tablet into the syringe barrel, add some water and one instantaneous shake will be followed by complete solution.

SHARP & DOHME

CHICAGO.

BALTIMORE.

NEW YORK.

NEW ORLEANS.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap
has been used ex-
clusively in this bat-
h from birth to
and her per-
fect skin and luxu-
riant hair excite
wonderful interest
and admiration.

AS A NUTRIENT SOAP
FOR THE SKIN . . .

Resinol Soap

IS WITHOUT A
. PARALLEL

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.
SYDNEY, N. S. W.,
Agents for Australasia

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

MEMOIR OF PROF. EDWARD LLOYD HOWARD, M. D.

By Dr. THOMAS S. LATIMER.

Dr. E. Lloyd Howard, fifth son of Charles and Elizabeth Key Howard, was born in Baltimore city January 14, 1837; was married to Miss Laura Maynard, May 3, 1877, and met his death by drowning September 15, 1881. By his mother, a grandson of Francis Scott Key, the author of "The Star Spangled Banner"; by his father a grandson of Col. John Eager Howard, his family history forms an important part of the history of the State of Maryland and of the country. He was a gentleman by birth and at heart. Educated at home by capable teachers, he possessed a well-stored mind, the best qualities of which, both moral and intellectual, were fostered and developed by daily intercourse with a noble father, a man of extensive erudition and judicial judgment, and who held his patent of nobility, if any man ever did, by divine right. The wisdom derived from his father received no alloy from the mother. The tenderness and truth of the mother's nature were marred by no stain of vice or harshness from the father. No man could have a better title to be a true gentleman, and he "wore without abuse the grand old name" thus derived.

I met him first in 1857, when we entered together the office of

Prof. Charles Frick to begin the study of medicine. His genial qualities soon endeared him to me, and I was fortunate enough to win his esteem and affection, which continued on terms of the closest intimacy until his death.

During his college term at the University of Maryland his superior intelligence soon became evident to his instructors and his classmates, by each of whom he was honored according to their positions and opportunities. He was a prominent candidate for the presidency of the class of 1861, in which he graduated, and his graduation thesis was published in "The Maryland and Virginia Medical Journal," then published under the active editorial management of a member of the Faculty of the University of Maryland—at that time a very unusual honor. Within a few weeks after graduation occurred the memorable struggle in the streets of Baltimore between the Massachusetts troops and citizens of this city. We were together enrolled on the following day as private soldiers in the Maryland Guard, where we continued during the exciting period that followed, until the State forces were disbanded by Governor Hicks. On the 7th of May, 1861, we started in company for Virginia, and were in Richmond subsequently enrolled in the first Maryland company organized in that city, under command of Capt. E. R. Dorsey, and after a month or two at a camp of instruction joined the other Maryland companies, commanded by Col. Arnold Elzey, at Winchester, Va. From here, after some little play in front of Gen. Patterson, we moved with Gen. Joseph E. Johnston to Manassas, in which first battle of the command, Dr. Howard exhibited that calm courage and obedience to orders which are the best qualities of a good soldier, and I am sure that on that field, where so many true men were, no man was less dismayed. As a private soldier but little opportunity for individualization is to be found, and nothing of special interest occurred to him during this period until the regiment went into winter quarters at Centerville, where an examining board was sent to the army to pass on the qualifications of medical men in the service for appointments to the positions of surgeons and assistant surgeons. Before this board, after a number of conversations together as to whether or not

'twas right to leave our friends and messmates in the ranks, we finally presented ourselves.

Dr. Howard was first examined, and although only a candidate for the position of assistant surgeon, and exceedingly youthful in appearance, his examination was so exceptionally good that he was recommended for and received the appointment of surgeon. On the opening of the campaign of 1862 he was assigned to a battery of light artillery under the command of Captain Courtney, of Richmond, and I know that he was esteemed and loved by every officer and private in this battery. Shortly after—during the same campaign—he was advanced to the medical charge of all the artillery in General T. J. Jackson's (Stonewall) Corps. The responsible duties of this position he discharged with zeal and ability, to his own great credit and the best interest of those entrusted to his care, until the close of the campaign, when, in consequence of some misunderstanding with the Medical Director of the Corps he was transferred to a North Carolina brigade under General Cook, of which he became Brigade Surgeon. Here also he was a prime favorite, and I am sure that I may safely say that there was not a member of that command with whom he sustained personal relations who did not become attached to him, and many of them yet living still hold him in grateful remembrance for acts of gentle and intelligent kindness shown in sickness and in suffering. In this position he remained until the surrender of General Lee at Appomattox, when he was paroled and allowed to return to Baltimore, where he very soon after engaged in the practice of his profession. In 1868 he was appointed Lecturer on Anatomy at Baltimore College of Dental Surgery, and in 1869 was elected Professor of Anatomy in that school. In 1870 we became partners in the practice of medicine, and together published and edited the *Baltimore Medical Journal*. In 1872 he was appointed Lecturer on Physiology in the College of Physicians and Surgeons; in 1873 was elected Professor of Anatomy and Clinical Professor of Nervous Diseases, and in 1874 was, at his own request, transferred to the chair of Physiology.

About 1870 he became a member of the American Medical Asso-

ciation, where he at once assumed a position granted to but few of its members. His great accuracy, habit of concise statement and logical force, coupled with a rich fund of definite knowledge, always secured for him a patient and attentive hearing, and in a little while he attained commanding influence in this association, that never waned. In 1872 he was appointed Secretary of the "Section of Psychology and Medical Jurisprudence," and in 1874 read before the Association an excellent paper on the "Legal Relations of Emotional Insanity," a subject in which he took a great interest, and for the discussion of which he was exceptionally qualified. At this session of the Association he was appointed a committee of one from the State of Maryland to endeavor to effect the passage of a law establishing a "State Board of Health," which he succeeded in accomplishing in 1874, and of which he was appointed Secretary by Governor Whyte. During this year he was transferred at his own request from the chair of Anatomy to that of Chemistry in the Baltimore College of Dental Surgery, in which he remained until the end of his life. In 18—, during the prevalence of a severe epidemic of typhus fever, which also attacked the Resident Physician at the Marine Hospital, Dr. Howard volunteered to take his place, and when appointed entered upon and discharged his duties with unshrinking fidelity until Dr. Conrad was happily restored to health. I think I am right in saying that there were no other volunteers for the position at that time, and I by no means wish to imply that there were not many brave men in the profession then, as always, who would have come forward had it been necessary; but they waited to see if their service might not be dispensed with. He stepped forward at once to see if his services might be useful. During a part of the time he was filling Dr. Conrad's position he was so much prostrated as to have fallen insensible upon several occasions, but no thought of deserting his post ever occurred to him, and I am sure that nothing short of absolute incapacity for work would have persuaded him to do so. In 1876 he was appointed to the charge of this hospital, resigning his position as Secretary to the Board of Health for the purpose. He was immediately after elected President of the Board. Both of these positions he continued to hold until his death.

As Secretary and President of the Board of Health, he acquitted himself ably, visiting many parts of the State, inspecting hospitals, jails, and other centres of disease, fearlessly commenting on abuses that he found existing, and always suggesting intelligent and practicable means for correcting them. He was never a dreamer, urging impossible reform by unattainable means, but always the clear-headed, judicious official, who correctly estimated the evil he was endeavoring to combat and the means available for that end. In 1879 he was offered by the U. S. Government the appointment, which he promptly accepted, of Commissioner to visit the yellow fever districts in the South, to ascertain, if possible, or as far as possible, the history and cause or causes of the epidemic then prevailing. That he should have been selected for this duty shows the national reputation he had achieved; that he should have accepted it was but one of many illustrations of his readiness to encounter hardship and danger in the discharge of a supposed duty. Whilst engaged in this work he was himself attacked by yellow fever, from which he made but an imperfect recovery. A tubular nephritis supervened from which he never recovered, and I entertain no doubt that the vertigo, of which he had repeated attacks, was of uræmic origin, and that to this, together with the extreme heat of the day, his fall into the water was due, so that his death may be justly ascribed to the disease incurred in the faithful discharge of the responsible and dangerous duty he had assumed. His mind was also very seriously impaired by this attack of yellow fever, so much so that for several weeks after his return he was quite insane, and altogether unfit to resume his position at the Marine Hospital.

During the entire session of the Health Association in Richmond, when the results of this investigation were discussed, Dr. Howard's mind was quite unbalanced; he was altogether unable to sleep, and spent the greater part of each night walking the floor in a state of great excitement. Hence the comparatively small part taken by him in the action of this body. Had he brought to its deliberations his normal intellectual force, unclouded by disease, he would have been recognized as one of the ablest of its members.

A mere statement of the leading incidents in Dr. Howard's life can give but an imperfect idea of his mental or moral characteristics. I think I never knew a more incisive intelligence. He had the "critic clearness of an eye that saw through all the Muses' walk"—

"A mind with strength and vigor bold to dwell
On doubts the coward dared not face;
Keen through wordy snares to trace
Suggestion to her inmost cell."

His strength in analysis was of the highest order, and only equalled by his synthetic force. No man I have ever known had a more comprehensive grasp of an intellectual proposition, or saw more clearly the value of its constituent parts; but he dallied with his subject always, holding it in view long enough only to show his mastery of it, and then carelessly dismissing it to the limbo of indifferent things. He was an illustration of the truth of Goethe's saying, "Thought widens, but lames." In nothing that he ever wrote did he show his real strength. A fatal habit of procrastination made all his public work hasty, immature, and, relatively to his capacity, but a slipshod expression of his power. It was not so with his reading or his thought. He was a most careful and thoughtful reader, never abandoning a line of investigation that interested him until he had mastered it in all its details and thoroughly comprehended its philosophy, and seldom without enriching it with something from his own mind. But somehow he was not aroused to action, his thoughts never crystallized into definite forms unless stimulated by sympathetic conversation or excited by discussion. He was not a ready writer, and could be induced to use his pen only when it was impossible longer to delay. He was, in 1875, invited to make an address at the formal opening of the Academy of Sciences, with ample time for preparation, but finished it only a few minutes before its delivery, and was late to his appointment. On another occasion (January 17, 1870) he was asked to deliver one of the lectures in the Peabody course; having selected the spectroscope for his theme, he postponed its preparation to the last moment, and when on the platform decided to abandon his manuscript—wisely, I think—and instead deliver an

extemporaneous lecture, which he did in a masterly way. It is my firm conviction that Dr. Howard had not his equal as a lecturer in Baltimore, and I am satisfied that if his lectures had been taken down by a stenographer, they would, with very slight alteration, have furnished a number of admirable papers, which would have enriched our literature and added in no small degree to his reputation.

Those who knew him intimately will, I am sure, sustain me in this opinion; for when speaking seriously he uttered nothing base or foolish. To all subjects he brought an understanding and cultivated mind that shed new light on every theme that engaged his attention; but his writings will, I think, rather tarnish than add lustre to his fame. His profession was not well chosen. He could not adapt himself to its daily requirements; had but little tolerance of disagreeable patients, and was too skeptical to be a successful physician. Had he chosen law, he would have been in his proper position. The excitement of debate was to him a healthy stimulus necessary to his mental activity. Always calm and unruffled, under no circumstances did he ever lose his mental balance. This fact alone made him a formidable antagonist, but left him always a courteous one.

His own convictions were clearly understood and tenaciously held, but the utmost tolerance characterized his judgment of the opinions of others. He was as far removed from bigotry as it is possible for a man to be. He had a noble scorn of shams and impostures of all kinds, and to these only was he intolerant. Honest convictions, however unwise, always received from him that courteous consideration to which they were entitled. He had a deep and discriminating love of the beautiful in all its forms; music and poetry, "meadows, hills, and groves," were ministering spirits to him, "sweet joy to bring." He was "brave for truth and strong for love." An almost sentimental attachment for everything that was tender and true and beautiful went hand in hand in his nature with a manly courage and dignity such as is rarely found, and I think this phase of his character not inaptly described in some lines of Wordsworth:

" Whose powers shed round him in the common strife,
Or mild concerns of ordinary life,

A constant influence, a peculiar grace;
But who if he be called upon to face
Some awful moments to which Heaven has joined
Great issues good or bad for human kind,
Is happy as a lover, and attired
With sudden brightness like a man inspired,
And through the heat of conflict keeps the law
In calmness made, and sees what he foresaw;
Or if an unexpected call succeed,
Come when it will, is equal to the need:
He who is thus endued as with a sense
And faculty for storm and turbulence,
Is yet a soul whose master-bias leans
To home-felt pleasures and to quiet scenes;
Sweet images! which wheresoe'er he be,
Are at his heart; and such fidelity
It is his darling passion to approve;
More brave for this, that he has much to love."

Somehow 'tis the fashion of men to hide the gentler and lovelier side of their natures from their fellow-men, and to this Dr. Howard was no exception. Indeed, he was not unapt to affect a dislike for things he loved most when with those whom he thought indifferent to or incapable of understanding them. A man cannot admit his general acquaintance into his holy of holies. He was a true and staunch friend, whom no danger and no hardship ever frightened from the most generous execution of his friendly obligations. Of this no man could have better evidence than myself. His purse, his time, his life were entirely at the service of his friend, and that not in a cold and formal recognition of friendly duty, but with a frank and cordial warmth that made one sure it was a happiness to him to serve those whom he loved. A truer friend never lived!

Am I then to be understood to imply that my friend was without fault? I would not so wrong his life or my own reputation for truth; but I am here to recite his virtues, not to recount his faults. It is not difficult to point to flaws in any character and to prove them real, but I am reminded of a story from Boccacini, in which I find my justification. A famous critic once, having gathered together all the faults of a distinguished poet, carried them as a present to Apollo, who, receiving them graciously, determined to properly reward the

critic for his trouble, and therefore setting before him a mass of unwinnowed wheat, bade him separate the grain from the chaff, and when he had done so presented him the chaff for his pains.

Over his follies and his frailties, of which we all have many, let us cast the mantle of oblivion. Of his virtues I have withheld more than I have uttered. A man's biography must be written by his friends, his enemies, or by those who are indifferent to him. Of these, who is fittest I need not say. The friend surely must know him best, and judge him most wisely:

"Passion is blind, not love. Her wondrous might
 Informs with three-fold power man's inward sight;
 To her deep glance the soul at large displayed,
 Shows all its mingled mass of light and shade;
 Men call her blind when she but turns her head,
 Nor scans the fault for which her tears are shed.
 Can dull Indifference or Hate's troubled gaze
 See through the secret heart's mysterious maze?
 Can Scorn and Envy pierce that dread abode,
 Where true faults rest beneath the eye of God?
 Not theirs 'mid inward darkness to discern
 The spiritual splendors how they shine and burn;
 All bright endowments of a noble mind,
 They, who with joy behold them, soonest find;
 And better none its stains of frailty know
 Than they who fain would see it white as snow."

HEREDITY IN DIABETES MELLITUS, WITH A REPORT OF SIX CASES OCCURRING IN A FAMILY.*

BY DR. J. HALL PLEASANTS.

I wish to report six cases of diabetes mellitus occurring among the members of a single family in three generations. The cases are of special interest since they illustrate very well certain features of the hereditary form of diabetes. Five of the six cases have been under personal observation.

Heredity has been long recognized as a factor in the etiology of diabetes, but its importance has been generally underestimated. The

* Read before the Johns Hopkins Hospital Medical Society, June 4, 1900.

first reference to diabetes as a family disease which I am able to find in the literature occurs in Richard Morton's *Opera Medica*, Amsterdam, 1696. In his chapter on diabetes he cites the case of a father and son who suffered from the disease. Among other early writers who called attention to the fact that heredity may sometimes enter, were Blumenbach and Isenflamm. In Rollo's *Cases of Diabetes Mellitus*, 1798, Storer of Nottingham directed attention to what he termed "mild habitual or family diabetes," and cited two families in which several members were diabetic. In one of these cases the father is said to have died of diabetes, while a son, a daughter and a granddaughter suffered from a mild type of the disease. Thomas in the same work reports a similar case. During the present century numerous writers have contributed to our knowledge of the part played by heredity.

Statistics showing the proportion of cases of diabetes in which heredity enters vary considerably, as the following figures, which I have collected, illustrate:

Flint	27.7%
Blouchard	25
Fitz and Joslin	23.8
von Noorden	21.8
Schmitz	21.1
Seegen	14
Naunyn	11.7
Zimmer	10.6
Williamson	10.5
Frerichs	9.75
Grube	7.9
Johns Hopkins Hospital Series (112 cases) ..	5.3
Wegeli (in children)	29

The marked variation in these figures is probably largely due to the class of patients upon which the different statistics are based. Those based upon hospital and dispensary cases are lower, owing to the difficulty in obtaining satisfactory medical histories from such

patients. Thus Naunyn reports from his private practice 17-20 per cent of cases giving a history of heredity, while of the patients from his clinic only 4.4 per cent gave such a history. For the same reason the figures based upon an analysis made by Dr. T. B. Futeher and myself of 112 cases treated at the Johns Hopkins Hospital and Dispensary up to June 1, 1900, are low. Fitz and Joslin omit cases in which the family history has not been especially inquired into, so that their figures are of especial value. It seems probable that heredity enters in from 20 to 25 per cent of all cases of diabetes.

The cases which I wish to report to-night occur in two brothers and two sisters, an uncle and a great uncle, as is shown in the accompanying chart-pedigree. With the exception of the great uncle, Heinrich D——, who died in Germany about fifteen years ago, all the cases have come under my personal observation. Apart from the diabetic taint the family history shows nothing of especial interest. All of the 23 descendants of the emigrant, Augusta M——, who are now living, are residents of Baltimore. With one exception, I have fortunately been able to make an analysis of the urine of all of these. In addition to these, one member of the family suffering from diabetes recently died at the Johns Hopkins Hospital, so that including Augusta M—— I am thus able to report upon the condition of 24 members of the family. In view of the interest at present attached to the so-called "conjugal diabetes," wherever possible the condition of those persons who have married into the family has been investigated. The result of these inquiries has so far been negative. The average of intelligence in the family is excellent. There is no history of epilepsy, insanity or other nervous trouble. One of the *diabetic* members of the family—John M—— has, however, had two attacks of delirium tremens. No luetic history is obtainable. Not a single member of the family is stout, but it is of interest to note that the father of the four diabetic brothers and sisters is a very large man, although the diabetic taint comes through the mother.

The following is a summary of the cases:

CASE I. Heinrich D——, the great uncle—of Goslar, Germany, is said by his sister to have died of "Zuckerkrankheit" fifteen years

ago at the age of forty. Three years before his death he was severely injured by a falling tree. Soon after the injury his general health began to fail. About one year previous to his death sugar was found in the urine. No further details of the case are obtainable.

CASE II. John M—— the uncle—aged 28.

Complains of nervousness.

Past History.—No acute diseases except measles and malaria, the latter two years ago. During the past seven years has suffered much from nervousness brought on, he thinks, by excessive drinking. Has had two attacks of delirium tremens within the past year. No history of lues.

Present Illness.—December 15, 1899, he was examined for admission into a beneficial society, and his urine found to contain sugar. Previous to this he did not know of the existence of diabetes. The examining physician reports to me that on two subsequent occasions sugar in large amounts was found to be present. The classical symptoms of diabetes are not very marked—the patient does not drink a very large amount of water, the urine is but slightly increased in amount, the appetite is moderate and there has been no marked loss in weight. He refuses to submit to a special diet.

Physical Examination.—The patient refuses to allow me to make a physical examination. In appearance he is tall and well developed. Color rather sallow. Seems very much upset about his condition. The examining physician informs me that nothing especial is to be made out in the chest or abdomen.

Urine Analysis.—This has been made by me twice. April 6, 1900: Sugar present, but the amount unfortunately not determined. Specific gravity 1036. No albumin or casts. April 24, 1900: Sugar .4%. Specific gravity 1020. Trace of albumin, no casts. No diacetic, β -oxybutyric acid or acetone present on either occasion. On the whole the case seems to be rather a mild one.

Cases III, IV, V and VI are brothers and sisters.

CASE III. Jacob S—— nephew—aged 20. Tailor by occupation. Came under observation March 30, 1900.

Complains of loss of voice and general weakness.

Past History.—No acute diseases except pneumonia when a child. No luetic history. Habits have always been good. Slight cough with expectoration for several years. One year ago his voice began to become weak and his cough more troublesome. The diagnosis of tuberculous laryngitis was made at the Johns Hopkins Hospital Dispensary, although diabetes was not suspected.

Present Illness.—There is no definite history of onset. About one year ago the patient began to suffer from thirst and dryness of the throat. Drinks a rather large amount of water at times. Frequently voids two or three litres of urine a day. Appetite is large. During the past year there has been considerable loss in strength and weight. There is no pruritus. Now suffers from severe cough and night sweats.

The patient did not know of the existence of diabetes until four or five months ago when he was informed of the fact by his physician. Since then he has been at times on a restricted diet.

Physical Examination.—In appearance the patient is a frail and badly-nourished boy. Very anemic; no xanthomata or other cutaneous lesions; no dryness of the skin; no fruity odor of the breath. The throat examination shows tuberculous ulceration of the larynx. Examination of the lungs shows an advanced tuberculous process in the upper left lobe, while there are signs of beginning involvement of the right apex. The physical examination is otherwise negative.

Urine Analysis.—March 29, 1900. Urine shows 2.9% of sugar. No diacetic acid; β -oxybutyric acid or acetone; urine otherwise negative.

CASE IV. Charles S—— nephew—aged 16; clerk. Came under observation March 30, 1900.

Complains of dryness of throat.

Past History.—No acute diseases except measles and chicken-pox; no luetic history; no history of malaria. Habits have always been good.

Present Illness.—The patient says that his general health is good. For the past year he has been troubled with dryness of the throat. Five months ago he had two fingers cut off by machinery. Following

this for several days he was very nervous and had a low fever which his physician called "malaria." Since then the dryness of the throat has increased. For the past year he has taken a good deal of water to drink, his appetite has increased and the amount of urine has increased. All these symptoms have become more marked since the accident. He thinks that there has been a slight loss in weight.

The patient was not aware of the existence of diabetes.

Physical Examination.—The patient is a well-developed and well-nourished boy, slightly anemic in appearance. There is no fruity odor of the breath. No zanthomata or other skin lesions; no dryness of the skin. The examination of the throat, thorax and abdomen is negative. Both knee-jerks are absent.

Urine Analysis.—This has been made twice. The patient has not been on a restricted diet. March 29, 1900. Sugar 3.7%; specific gravity 1037; no diacetic acid or β -oxybutyric acid. There is a distinct trace of acetone. Urine otherwise negative. March 31, 1900 (24 hours' specimen); amount in 24 hours, 2050 cc.; sugar 5.3%; specific gravity 1041. No diacetic acid, β -oxybutyric acid or acetone.

CASE V. Augusta S— niece—aged 16; schoolgirl.

Came under observation April 1, 1900.

There is no complaint about her health.

Past History.—The patient has always been strong and healthy. Chills and fever every other day when about six years of age. Measles and chicken-pox as a child. The patient is subject to attacks of tonsillitis. She first menstruated five months ago.

Present Illness.—The patient says that she feels strong and well. Her appetite is quite large; drinks a good deal of tea and coffee; does not suffer much from thirst; no dryness of throat; voids between two and three litres of urine a day. The patient does not know how long she has been voiding this much, and has never thought the amount excessive. It is impossible to assign the time of onset of the disease. There is no dryness of the skin, zanthomata or skin eruption. The patient was not aware of the presence of diabetes.

Physical Examination.—The patient is a well-developed and very well-nourished girl. The complexion is brilliant. Lips and mucous

membrane are of a good color. There is no fruity odor of breath. There are no zanthomata. An examination of thorax and abdomen is not permitted. Seems in excellent general physical condition.

Urine Analysis.—Two analyses have been made. The patient has not been on a special diet. April 1, 1900: Sugar 1.5%; considerable albumin; no diacetic acid, β -oxybutyric acid or acetone. April 30, 1900: Amount in 24 hours 2600 cc.; sugar 1%; specific gravity 1016. No diacetic acid, β -oxybutyric acid or acetone; trace of albumin.

CASE VI. Drucilla S—— niece—aged 10. Schoolgirl.

Admitted to the Johns Hopkins Hospital March 22, 1900. Died April 6, 1900.

Admitted complaining of rheumatism.

Past History.—Measles when six years of age. There have been three previous attacks of rheumatism; no history of malaria.

Present Illness.—For three weeks preceding her admission the patient had been suffering with acute articular rheumatism. She also complained of pain about the heart. Had never noticed that she drank much water or that she voided much urine. Appetite is not large. At times she had pruritus of the scalp. There has been no decrease in strength or weight.

Physical Examination.—The patient is a fairly well-nourished girl. Not anemic in appearance. There are no zanthomata or other cutaneous lesions; no dryness of the skin; odor of breath not fruity. There is considerable tenderness over the involved joints. The heart-dulness is increased, and there is a loud systolic murmur at the apex. A marked friction rub is heard over the body of the heart. Nothing further made out on examination.

After admission to the hospital her condition gradually became worse. She died April 6, 1900, with all the symptoms of cardiac disease. During the greater part of her illness there was considerable fever, often reaching 104° . None of the symptoms of diabetic coma were present at any time. The blood examination did not show the existence of lipemia. There was a slight reaction with Bremer's test.

The patient was at no time on a diet entirely free from carbohydrates.

Urine Analysis.—During the fifteen days that the patient was under observation in the hospital a very careful daily determination of the sugar, diacetic acid, β -oxybutyric acid, acetone, ammonia and urea was made by Dr. Erlanger. The amount of urine in 24 hours varied from 740 to 2260 cc. The sugar ranged from 1.5 to 4.6%. The specific gravity ranged from 1016 to 1039. At times, diacetic acid, acetone and β -oxybutyric acid were all detected in the urine, the latter on one occasion reaching .35%. The urine towards the last contained a trace of albumin, but no casts.

Autopsy.—Fortunately a post-mortem examination was obtained. The heart showed the presence of a marked endocarditis and a serofibrinous pericarditis. The examination of the abdominal organs showed nothing of importance. The pancreas was possibly slightly enlarged, but microscopical examination revealed nothing abnormal. The liver was practically normal. The brain and cord could not be examined.

An analysis of these six cases brings out certain points of interest which illustrate well some characteristic features of hereditary diabetes. An inspection of the chart-pedigree shows that the disease was probably inherited through the great grandfather Bernhard D—, as he has diabetic descendants through both of his wives, although considering the advanced age at which he died—88—it is improbable that he himself suffered from the disease. The grandmother—Augusta D— is living and well. Her urine is absolutely negative. The same is true of Theresa S—, the mother of the four diabetic children. These cases thus bring out very well what I have called the “collateral inheritance” of diabetes, there being probably no history of diabetes in an ancestor in three generations at least. The age at which the disease has first made its appearance is a more difficult matter to determine. In the case of the great uncle it was discovered at 40, in the uncle at 28, and in the four nephews and nieces at ages ranging from 10 to 19. We have here the disease appearing in succeeding generations at a progressively early age. In the third generation the disease has appeared approximately at the same period of life; i. e., all the cases are in the second decade. In

regard to the severity of the disease in the family under consideration, it is as yet, too early to speak definitely. The cases at present under observation do not seem to be of a severe type, in some of the cases the existence of any trouble being unsuggested. In the one fatal case which I have been able to observe, death was not due to diabetes. As stated previously there is no definite neurotic family history or history of obesity.

The negative evidence which has been brought forward by a study of the urine of 24 out of 25 members of the family, is of interest, and should additional members of the family at a later time develop the disease, will be of importance in determining the time of its onset. If possible the family will be kept under observation and any later developments which may be of interest will be reported.

MENINGOCELE.

By FRANCIS P. O'NEAL, '02.

In considering the malformation of the brain, known as meningocele, there are two other conditions which are very similar in appearance and make up, and often require great care to be distinguished from meningocele; these conditions are known as encephalocele and hydrencephalocele.

Meningocele, encephalocele and hydrencephalocele are, commonly speaking, hernias of the brain, that is, protrusion of the meninges of the brain, and sometimes of the brain substance through abnormal orifices in the skull. The most common locations of these orifices are in the occipital region, along the median line and in the frontal region, a little to one side of the median line near the root of the nose, but these protrusions may also be found in various other parts of the skull.

The malformations found in the frontal region are usually smaller and not so dangerous as those found in the occipital region.

To distinguish these three conditions, we speak of meningocele as a protrusion of the dura mater and arachnoid through an abnormal

orifice of the skull, forming a sac which is filled with cerebral fluid. Encephalocele is a protrusion, not only of the membranes of the brain but also of a portion of the brain substance which is surrounded by the cerebral fluid; and hydrencephalocele is a protrusion of the membranes and brain substance, in which the interior of the mass communicates with the ventricles of the brain and contains ventricular fluid.

Hydrencephalocele is the most frequent and most serious of the three conditions. Encephalocele comes next, while meningocele is the rarest and least dangerous of the three conditions.

Treves gives the following points, in distinguishing these various conditions: In meningocele, the tumor is at first small, but increases in size; it has a smooth surface; it is pedunculated; there is distinct fluctuation, perfect translucency, rarely pulsation; often it is completely reducible; compression of the tumor causes cerebral symptoms; the skull is normal.

In encephalocele, the tumor is small and smooth; it is rarely pedunculated; fluctuation is absent; it is not translucent; there is distinct pulsation; it is usually reducible; pressure causes cerebral symptoms; the skull is normal.

In hydrencephalocele, there is a large pendulous tumor with an irregular or lobulated surface; it is pedunculated; translucency is rarely complete; fluctuation is distinct; it is irreducible; pressure rarely causes symptoms.

Holt states that the occipital tumors are more serious than the frontal, the majority of cases dying in the course of the first few weeks of life from meningitis, convulsions or rupture.

The theory of the origin of these malformations, which is most widely accepted, is that they are, primarily, cases of intrauterine hydrocephalus, and, as the cranial cavity has gradually been closed by the development of the bones, a certain portion of the brain has been left outside.

There are a great many of these malformations mentioned in the earlier literature, but the various forms are not specified clearly enough to be able to make out any statistics as to each separate form.

Of 105 cases of brain malformations, reported by Schatz, 59 occupied the occipital region, and 46 the frontal region. Of those occupying the occipital region, 24 were of the hydrancephalocele type, and 35 of the encephalocele type. Of those occupying the frontal region, 32 were of the hydrancephalocele type, and 14 of the encephalocele type.

Of the 24 cases of occipital hydrancephalocele, 4 were born dead, 4 died during first two days, 4 died during first 14 days, 1 during 3rd week, 1 during 4th week, and 1 during 5th week. Six died at an early period, but the exact time is not known. Three were still living at the time of the report, the first being 1 day old, the second 19 days old, and the third 18 years old.

Of the 35 cases of occipital encephalocele, 6 were cured by puncture followed by compression, 5 were operated on with ligature and all of these died, 3 were operated on with the ecraseur, and of these three, only one was saved, the other two dying.

Of the 32 cases of frontal hydrancephalocele, there was one foetus, 2 died on 1st day, 5 during 1st week, 5 during 1st two weeks, 3 during 1st six weeks, 1 in 11th week, 1 at 5th month, one at 54th month, and 1 at time unknown. One lived to be 58 years old. At the date of the report, there were five living, being 3 months, 2 years, 9 years, 20 years, and 33 years of age, respectively.

In nine cases of meningocele reported, three were cured; the first by excision, the second by injection of iodine solution, and the third by the use of the ligature. Two died after the meningocele had been punctured, and one died after the solution of iodine had been injected. The other three cases were treated without any result.

Chelius reports several cases of brain malformations in adults: a man aged sixty years, another aged thirty-three years, a weak-minded boy aged eighteen years, a girl aged twenty years, another girl aged twenty-three years who was an idiot, and a negro girl aged seventeen years.

T. Holmes reports from St. George's Hospital, London, two cases of meningocele which were treated with seemingly good results by the iodine injection, but both contracted capillary bronchitis and died.

Leasure reports a case of hydrencephalocoele which was treated by compression and was cured.

In Virchow's work on tumors, there is a remarkable case described where the opening in the skull was just anterior to the sphenoid bone. The fluid passed from this into an irregular tumor which projected from the roof of the mouth, between the lips, for a distance of several inches.

There is another condition produced after birth by fracture of skull, known as false meningocele, in which the cerebral fluid passes out under the scalp. This elevation may pulsate, may be tense during crying, and may cause symptoms on pressure.

Weinlechner collected seventeen of these cases prior to 1884. Of these cases, eleven were treated by simple puncture, and of these, four died, three healed, and in four the result was not known.

Nicoladoni treated a case successfully by aspiration followed by injection of iodine. The sac entirely disappeared in six months, after six punctures.

Snow reports a case of a child eight months old who had several falls. Suddenly a swelling appeared in the occipital and whole right parietal regions, in which there was no pain, no fever nor local inflammation. This case was cured by pressure.

The cases reported since the introduction of modern methods of surgical work are too small to admit of a criticism as to the value of excision. Hutchison, however, makes a very pointed statement, that in every ten cases operated upon, but one recovers. There have been, however, a number of patients who have recovered from the operation, but who have died subsequently from other diseases, the condition, apparently, being one which lowers the vitality to a very marked degree.

It must not be forgotten that some cases tend to a spontaneous cure. Two of these may be mentioned where the tumor was the size of a small orange, but these cases are very rare.

Unsuccessful treatment may often be the result of a wrong diagnosis.

In conclusion, it may be said that the treatment of brain malformations is a varied one, the three means, generally used, being compression, aspiration followed by the injection of iodine solutions, or excision.

A CASE OF MENINGOCELE.

(SERVICE OF DR. J. W. CHAMBERS)

DR. L. J. OWEN, REPORTER.

Patient was a white female child, aged 26 months. Admitted to hospital October 22, 1901. Family history was good, father and mother in good health. One brother, aged 4 years, well developed and healthy.

Past History.—When born had a tumor on back of head about the size of an egg. This tumor increased steadily in size, while the child's general development remained poor. About eight months ago the tumor ceased to enlarge and after that time the child's development progressed rapidly. Had cut most of her teeth; gained in strength and weight; and learned to talk a little.

Present History.—When admitted to hospital appeared to be in excellent health. Face well formed but head somewhat small and flattened antero-posteriorly and on top. The occipito-frontal circumference $16\frac{3}{4}$ inches.

The length of the child $30\frac{1}{2}$ inches. Limbs and trunk well developed and strong. Mental condition fairly good. Mass on back of head attached in median line of occipital region and of enormous size. It was round or ovoid in shape (accommodating itself to the position of the child), and measuring 33 inches in circumference.

In appearance it was the color of normal skin and covered with hair only close to the head. In spots the epidermis was rough and broken. On palpation it was smooth, fluctuating and attached by a short pedicle. It was not in the least sensitive and pressure produced no discomfort (the child usually lying with the weight of its head and shoulders on the tumor). The sac felt thick and dense, and no pulsation could be felt.

In view of the high mortality rate in all these cases, the results to be expected of surgical intervention were not encouraging, but on account of the absolutely helpless condition of the child and the almost inevitably fatal result without treatment, an operation for the removal of the tumor was undertaken.

The head and tumor were shaved and cleansed as thoroughly as possible. No anæsthetic was given. An incision was made around the pedicle, just where it expanded into the tumor, and through the integument only. The flap thus formed was dissected up toward the head, exposing the sac at its point of communication with the interior of the skull. The opening in the bone being about one-half inch in diameter. A strong ligature of silk was tied around the pedicle at this point and the tumor removed by cutting through the pedicle on the distal side of the ligature. The edges of the stump of the pedicle were inverted and united with a continuous silk suture; the ligature was then removed. The skin flaps were then united over the stump with interrupted silk-worm-gut sutures.

The patient did not seem to suffer much pain, but toward the close of the operation showed some signs of shock. Whisky and strychnia were administered hypodermatically and continued several hours.

With the exception of a rather high temperature (102° to $103\frac{1}{2}^{\circ}$ F.) and rapid pulse, the patient's condition continued good until 7 P. M. October 25, the second day after the operation, when she had an attack of vomiting followed by a slight convulsion. These convulsion increased in frequency and severity and only terminated with the death of the patient on October 27 at 3 P. M.

During the convulsions the muscles of the entire trunk and the extremities became perfectly rigid and tense, and continued so for several minutes. Chloral, potassium bromide and morphia were all tried without effect, and only by the liberal use of chloroform could they be checked. At 7 P. M. October 26, the temperature had reached $105\frac{3}{5}^{\circ}$; the left pupil was more dilated than the right, and there was no expansion in the left side of the thorax. Pulse was

much weaker and too rapid to be counted. Patient remained in this condition, with a gradual weakening of the pulse, until the time of her death.

Pathological Report.—The tumor, before being evacuated, measured 82.5 cm. in length, 75 cm. in breadth and 67.5 cm. in depth. It had a pedicle which measured 6.5 cm. in length and thickness.

Its contents were fluid, clear at first, and measured five thousand eight hundred and seventy-five cc. (5875 cc.). The fluid had a specific gravity of 1010, slightly alkaline in reaction, and rich in albumen and peptone.

The microscopic elements in the fluid (red and white blood corpuscles and epithelia) were probably the result of trauma during the operation.

The cyst wall varies from 5 to 16 mm. in thickness. Viewed as a whole, the tumor is spherical in shape and its walls seem to consist of the natural tissues of the scalp augmented by the serous membranes of the brain. The diameter of the cyst when collapsed is 28 cm. in either direction.

Its internal surface, mottled in appearances and showing distended vessels. Three fibrous bands about 4 mm. in thickness and varying in breadth from 1 to 45 cm., radiate from the pedicle and suggest a possible partial sacculation at an earlier period.

The internal surface of the cyst wall has a glistening appearance, due to the serous membrane which covers it.

Microscopically, the wall is principally made up of normal epidermis, covering a thick layer of subcutaneous connective tissue. The internal covering consists of a tissue rich in blood-vessels and connective-tissue cells. The inner covering is in no place smooth or covered by endothelial cells. In certain areas it is covered by a thin layer of tissue resembling brain tissue. Under the high power much of this tissue shows a thickening of the neuroglia. This misplaced brain tissue is only present in sections taken from certain areas of the tumor and is entirely absent in other sections.

The tissue between the adherent cerebral matter is certainly not a normal dural membrane, as it is much richer in blood-vessels and connective cells, at times even showing small cell infiltration.

Pathological Diagnosis.—Encephalo-meningocele.

A number of fatal cases of tetanus have followed vaccination recently in Camden, Atlantic City, Bristol, Brooklyn, Cleveland and St. Johns, N. B. In every instance where a careful examination has been made it was shown that the vaccine virus was free from the tetanus bacillus. This means of course that the tetanus infection had no more relation to the vaccination than it might have to any skin abrasion. A little more care in the after-treatment would have prevented these unfortunate results.

We are indebted to Dr. J. W. Johnson, '93, of Torrington, Conn., for the clippings from the local papers concerning the death of Dr. La Bonte, mention of which will be found elsewhere in the JOURNAL.

WILLIAM S. GARDNER, M. D., EDITOR,
1012 McCulloh Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER.
Postal Station No. 202.
Telephone, C. & P., Tuxedo, No. 303.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

LANTERN PROJECTIONS IN MEDICAL TEACHING.

We are constantly seeking for new methods of teaching medicine, for methods that will at once render the subject-matter more comprehensive and lighten the task of both student and teacher. There are many things that cannot be described by words as easily as by illustrations. Attitudes, facial expressions and the like must be seen to be appreciated. We cannot always have on hand the cases to show, but we can have on hand their photographs. These, when made into lantern slides, may be projected on a screen in a darkened lecture room and each student can see the picture at the proper time. This means of teaching by lantern projections has been, until a comparatively recent date, very much neglected in medicine.

In most of the European clinics this method of teaching has been in vogue for sometime; in some places the ordinary projections being used, and in others the projection microscope. Particularly in the German clinics is the latter in constant use. In America some few teachers have been using the lantern, but it has not been in as general employment as its value would lead one to suppose it should have been.

With the ordinary lantern and slides a great number of subjects can be illustrated. In anatomy, operative surgery, gynæcology,

obstetrics and such subjects its value is at once apparent. In general medicine and in neurology it is also of the greatest benefit. For example, a didactic lecture on the Spinal Paralyzes of Children is to be illustrated. At the proper time in the lecture the student is shown the lesions in the cord and subsequently the photographs of the patients themselves. If no patients happen to be available for the clinic, the student will have gotten an idea of this disease which he otherwise could not have had. Even if cases are shown the manifold late conditions are not, as a rule, present at the same time, and in a few minutes everything of importance may be presented to the students by means of pictures. Attitudes, expressions, atrophies and contractures may all be taught in a most impressive way, and the points made in the lecture be delightfully emphasized.

With the projection microscope both normal and pathological histology may be taught, and this is of especial value in laboratory demonstrations where the students are present in greater proportion than demonstrators. It is not to supplant the microscope at all, but merely to save the time and energy of the teacher. Those who have taught laboratory classes know how wearisome it is to repeat time after time the same thing to a large class of students.

It is not our purpose to call attention to the manifold uses of projections, but suffice it to say that from our own experience, both as student and teacher, without and with this means of teaching, we can unhesitatingly vouch for its value.

We are pleased to note in this connection that the College is provided with a good lantern and that it is being used by a number of the teachers this year and will be used by others as soon as lantern slides can be collected.

R.

COLLEGE MEDICAL SOCIETY.

A meeting for the purpose of re-organizing the College Medical Society was held October 17, 1901, at 8.30 P. M.

The following officers were elected: John H. Doyle, President; S. A. Reich, Vice-President; Samuel T. Darling, Secretary.

Dr. John Ruhräh was elected chairman of the Executive Committee, which consists of the following gentlemen: W. M. Garrison, E. F. Wehner, and F. P. O'Neal.

Previous to the election of officers, Dr. Ruhräh addressed those present on the subject of syringomyelia, illustrated by many excellent lantern slides.

At the meetings held October 31 and November 14, the following subjects were presented:

A biographic sketch of a former member of the faculty, Professor E. Lloyd Howard; by Professor Latimer.

Report of a case of meningocele: exhibition of specimen and photographs; by Dr. L. J. Owen.

A paper on the literature of meningocele; by Mr. F. P. O'Neal.

Exhibition of sections of the meningocele specimen; by Professor Stokes.

Clinical history and exhibition of a case of popliteal aneurism; with a brief account of the history of the operations and treatment of aneurisms.

Virchow: an account of his early life, development, and contributions to pathology. The paper was prepared by Mr. W. M. Garrison and Mr. E. F. Wehner; read by Mr. Wehner.

Report of history of case of aortic aneurism, with an account of the post-mortem examination and exhibition of specimen; by Mr. J. M. Hoag.

Notes on mitral stenosis, with report of case; by Mr. R. D. Walton.

Notes on the pathology of mitral stenosis; exhibition of specimens; by Mr. G. L. Hilton.

The meetings were well attended, and the subjects of the papers treated to liberal discussion.

PHI BETA PI.

There have been many attempts at organizing College societies at the P. & S. Some of these have gained more or less prominence in the College circle and have lent a certain color to College life. I

refer especially to the later organizations which were chiefly made up of hospital men with, of course, a fair number of students. Among these may be mentioned the "Samstagnachtverein," "The Brannigan Sons of Purity" and "The Bacillus Club."

And now we have a Greek Letter Fraternity established at the College.

At a meeting held November the thirtieth, at Dr. Beck's office, an application was made for admission to the Phi Beta Pi Fraternity. The application was favorably received by the Supreme Chapter, at Pittsburg, and the Charter forwarded. A second meeting was held on December the seventh, and arrangements made for a banquet the night of the formal installation.

The ceremonies of installation took place on the evening of December the tenth, and will always be most pleasantly remembered by all those who took part. The Supreme Argon, Dr. Mayer, being unable to be present, the ceremonies were conducted by his very able representative, Dr. Roscoe Evans, the Supreme Secretary. He was assisted by Dr. E. A. Weiss, of Pittsburg.

The Chapter organized is known as the Zeta Chapter of the Phi Beta Pi Fraternity. The following are the charter members: Drs. Harvey Beck, Emil Brack, Frank Dyer Sanger, Harry Friedenwald and John Ruhrah of the Adjunct Faculty, and Messrs. William M. Garrison, Edward F. Wehner, J. A. Riedy, B. S. Preston, Samuel T. Darling, C. W. Lurtin, T. J. Cummins and W. S. Evans of the Students.

After the formalities had been completed the members of the Chapter enjoyed a banquet at the Academy Hotel. Impromptu toasts were given by Messrs. Evans, Weiss, Friedenwald, Beck, Sanger, Evans and Darling. Dr. Ruhrah acted as toastmaster.

The Phi Beta Pi Fraternity was organized in Pittsburg in 1891, and so is quite young for a Greek Letter Fraternity. It is purely medical in its nature and all the members are either medical students or graduates in medicine. There are chapters at a great many of the various medical schools of the country. Among these may be mentioned University of Michigan, Rush at Chicago, Starling at Columbus, Ohio, and McGill at Toronto.

THE NURSES COMMENCEMENT.

The Commencement Exercises of the Training School for Nurses of the City Hospital were held in the College Ampitheatre, Friday afternoon, December 27, 1901, at 3.30 P. M.

The class, which is the first one to be graduated, consisted of Misses Sara Ward, of Virginia; Anna C. Donlon, of Pennsylvania; Lillian Oeligrath and M. Clare McGuire, of Maryland. Miss Ward received the medal for the highest average.

The ceremonies consisted of an Opening Prayer, by Rev. Wm. J. Kane; an Address, by His Eminence James Cardinal Gibbons; the Awarding of the Diplomas and of the Medal, by Dr. Latimer; an Address by Dr. Opie, and the Benediction by the Cardinal.

After the exercises there was a reception and a collation in the parlors of the hospital. The Reception Committee consisted of Drs. Bevan, Trimble and Preston.

The whole affair was regarded by all as a most successful culmination of the first three years' work in the Training School, and reflects the greatest credit on those who had charge of it.

THE POST-GRADUATE COURSE.

The catalogue of the Post-Graduate Courses is out and shows most creditable work by the Executive Committee on the part of the Adjunct Faculty who compiled it. This committee is composed of Dr. Harry Friedenwald, Chairman, together with Dr. Harvey G. Beck and Dr. Thomas R. Brown.

The courses will be given from April 28 until the 9th of June, and are arranged for the general practitioner who wishes to brush up his knowledge of general and special medicine and for the man who wishes to do work along the lines of the specialties. The courses are so arranged that those attending may take what they want and leave the rest alone.

The studies are arranged under four groups: Medicine, Surgery, Medical and Surgical Specialties, and Laboratory Courses. The

latter include work in Clinical Laboratory, Pathology, Bacteriology and Pharmacology.

The work in the other branches will be of a most practical nature, consisting of ward classes with bed-side instruction and the examination of patients and specimens by the students themselves. An especial effort will be made to have the work treat as fully as possible of the advances that have been made in medicine in recent years.

Another point of interest about the course is the evening lectures. There will be given three times a week in the evening lectures on the progress of medicine and on special medical topics. These evening lectures will be open to the public, and it is the intention to invite the profession of Baltimore to hear them.

DR. LOUIS DEGONZAGUE LA BONTE, '94.

It is our painful duty to record the death of Louis La Bonte, '94, from typhoid fever at his home in Derby, Conn.

All the men of the class of ninety-four will be especially pained to hear of his untimely demise, for he was one of the best known members of the class and one of the most popular.

Louis La Bonte was born at Stafford Springs, Conn., in 1870. He was of French extraction and his family among the prominent Catholics of his native town. He was educated first in the common schools and then at the College de l'Assumption, at Montreal. After he was graduated from there he studied medicine at the College and after receiving his degree went to New York for several months, where he studied in Bellevue Hospital. He then settled in Shelton, Conn., but after two months removed to Derby where, after a year's practice, he returned to his native town and opened a pharmacy. This was not to his liking, however, and he returned to Derby, where he gained a reputation for skill and judgment, and had at the time of his death one of the best practices in the town. He was a member of the Board of Education and served three and a half years as Health Officer.

In 1895 he was married to Miss Cora Goodwin, of Yonkers, New York. She and a daughter survive him.

On October 4, he was forced to give up work after having had a couple of weeks of ill health. Typhoid symptoms of a most severe character developed, and after several severe hemorrhages he had a perforation of the intestine. He was promptly operated on by Dr. B. Austin Cheney, of New Haven, but he died of shock on October 19, 1901.

The news of his death was the cause of many expressions of regret and sympathy for his family about the College, and the JOURNAL joins his many friends in thus voicing their common grief.

Personal Notes.

DR. THOS. ODELL, '81, has located in Gainesville, Texas.

DR. GEO. B. KLINE, '87, is located at 4819 Scioto St., Pittsburgh, Pa.

DR. JOHN W. LITTLETON, '85, died in Greensboro, N. C., November 2, 1901.

DR. C. H. BOSWORTH, '82, is now practicing at Wyalusing, Bradford Co., Pa.

DR. O. T. SPROUELL, '86, is secretary of The Adams County (Ohio) Medical Society.

DR. ALFRED NAULTEUS, '82, has removed from Hasting, Neb., to Deadwood, South Dakota.

DR. T. O. LINTHICUM, '88, died November 11, 1901, at Corbins, Caroline Co., Va., aged 45.

DR. E. E. CLARK, '93, of Knoxville, Pa., brought a patient to the City Hospital in December.

DR. JOHN PEALE BISHOP, '86, a prominent physician of Charleston, W. Va., died at his home November 5, 1901.

DR. E. R. ZEMP, '94, is professor of Materia Medica and Therapeutics in the Tennessee Medical College, Knoxville, Tenn.

DR. EDMUND A. MUNOZ, '92, Captain Fifth Regiment M. N. G., was married to Miss Lena Custis Wise at Baltimore, December 7, 1901.

DR. D. M. MILLER, '87, of Indian Springs, Sullivan Co., Tenn., was at the City Hospital with a patient to consult Dr. Chambers in December.

DRS. E. A. BOWERMAN, '95, B. W. SHIREY, '95, S. H. ALLEN, '90, and W. M. SIVEY, '94, are all taking course in clinical laboratory work with Dr. Charles E. Simon.

Cards have been received by the friends of DR. DAYTON LONG, '96, formerly Resident Physician at the Maternite. The cards explain themselves. They read as follows:

"Mr. and Mrs. Edgar Hastings Shook request the honor of your presence at the marriage of their daughter, Mabel Helen, to Doctor Dayton Joseph Long, Wednesday Evening, November Twenty-seventh, Nineteen Hundred and One, at half after seven o'clock, St. James Church, Westernport, Maryland. Reception from Eight until Ten."

After a wedding journey north, Dr. Long and his wife have settled at Piedmont, where the doctor has a large practice.

PITTSBURGH, PA.

W. J. TODD, M. D., College P. & S., Baltimore.

Dear Doctor.—Enclosed find five dollars to apply to my aid in relation to the Alumni paper. Please continue to send it to my home, 2139 Wylie Ave., Pittsburgh, Pa. I have long since fully recovered from my severe illness of last winter. Am now Police and Fire Surgeon, also Physician to the Bureau of Health of Pittsburgh. That, in addition to my own private work, keeps me busy.

I am yours very truly,

FRANK J. PHILLIPS.

Purity at Any Cost!

The careful physician is becoming more and more particular about the quality and source of his diphtheria antitoxin.

He demands a serum of responsible manufacture—a serum of known potency—a serum that is reliable—a serum that is safe!

Whose antitoxin best fulfills these requirements?

This is a question that concerns every physician—a question that is vital.

Our Antidiphtheritic Serum has an unbroken record as a saver of human life.

In the seven years of its manufacture we have marketed millions of doses.

During all that time it has never caused a fatality—never caused a mishap.

The scientific methods used in the preparation of our Antidiphtheritic Serum preclude the possibility of contamination.

The bacteriological and physiological tests to which we subject every parcel of it before it leaves our laboratories make doubly sure its absolute reliability.

We guard every step of the way—from first to last we never relax our vigilance.

Purity — PURITY AT ANY COST! — this is our watchword.

Parke, Davis & Co.

BRANCH HOUSES:

New York, Kansas City,
Baltimore, New Orleans, Chicago;
London, Eng.; Montreal, Que.

Home Offices

and Laboratories,

DETROIT, MICH.

BRANCH LABORATORIES: Hounslow, Eng.; Walkerville, Ont.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOOKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, N. Y., Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S. Ohio.
E. PARMLY BROWN, D. D. S. N. Y.
A. L. NORTHROP, D. D. S. N. Y.
E. L. HUNTER, D. D. S. N. C.
W. W. WALKER, D. D. S. N. Y.
OSCAR ADELBURG, D. D. S. N. J.
G. MARSHALL SMITH, D. D. S. Md.
C. M. GINGRICH, D. D. S., Resident. Md.
J. HALL MOORE, D. D. S. Va.

R. B. DONALDSON, D. D. S. D. C.
H. A. FARR, D. D. S. N. Y.
J. EMORY SCOTT, D. D. S. Md.
C. L. ALEXANDER, D. D. S. N. C.
M. M. MAINE, D. D. S. Conn.
J. W. DAVID, D. D. S. Texas.
A. C. BREWER, D. D. S. Md.
J. ROACH, D. D. S. Md.

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

W. W. DUNBRACCO, D. D. S. J. K. BURGESS, D. D. S. J. C. SUTHERLAND, D. D. S.
GEO. V. MILHOLLAND, D. D. S. CHAS. THEBERATH, D. D. S.
L. M. PARSONS, D. D. S. HARRY E. KELSEY, D. D. S. C. H. CARSON, D. D. S.
H. M. LEVER, D. D. S. C. S. GORE, D. D. S. L. F. PALMER, D. D. S.
C. R. STEWART, D. D. S. L. D. CORIELL, D. D. S.
H. H. HAYDEN, M. D., Demonstrator of Anatomy.
C. F. BLAKE, M. D., Demonstrator of Anatomy.

The Sixty-Second Annual Session will commence on the 1st of October, 1901, and continue until May, 1902.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.

ANNOUNCEMENT
OF
POST-GRADUATE COURSES
FOR
PRACTITIONERS OF MEDICINE

Beginning April 28th, 1902, and continuing for six weeks. These embrace courses in *Medicine* (including daily visits to the medical wards), *Pediatrics* and *Nervous Diseases*, *Surgery* (general, orthopedic, genito-urinary surgery and cystoscopy), *Gynecology*, *Operative Obstetrics*, *Ophthalmology* (including a course in the use of the Ophthalmoscope), *Otology*, *Laryngology*, *Pathology* (Demonstrations of fresh specimens and microscopic course), *Bacteriology* and *Clinical Laboratory* courses in the microscopic and chemical examination of the blood, urine, gastric juice, faeces, etc., etc.

These courses *are entirely practical*.

A certificate of attendance will be given at the end of the course.

For schedule and further information apply to

DR. HARRY FRIEDENWALD, CHAIRMAN,

College of Physicians and Surgeons,

BALTIMORE, MD.

College of Physicians and Surgeons OF BALTIMORE.

FACULTY

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- AARON FRIEDENWALD, M. D.,
Professor of Diseases of the Eye and Ear.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Medical Jurisprudence and Director of Pasteur Institute.
- C. HAMPSON JONES, M.B., C.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, M. D.,
Professor of Obstetrics.
- WM. ROYAL STOKES, M. D.,
Professor of Pathology and Bacteriology.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- W. F. SMITH, A. B., M. D.,
Associate Professor of Surgical Anatomy.
- B. HOLLY SMITH, M. D., D. D. S.,
Professor of Principles and Practice of Dental Surgery as applied to Medicine.
- HARRY FRIEDENWALD, A. B., M. D.,
Associate Professor of Diseases of the Eye and Ear.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MCLEARY, M. D.,
Associate Professor of Physiology and Demonstrator of Histology and Pathology.
- CHARLES E. BRACK, M. D.,
Associate Professor of Obstetrics.
- JOHN RUHRÄH, M. D.,
Associate Professor of Diseases of Children and Demonstrator of Pathology.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy and Demonstrator of Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Clinical Professor of Diseases of the Rectum.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MCGLANNAN, M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- MELVIN ROSENTHAL, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- ALBERTUS COTTON, M. D.,
Demonstrator of Osteology and Lecturer on Orthopaedic Surgery.
- GLENN M. LITSINGER, M. D.,
Demonstrator of Obstetrics.
- M. EKSTROMER, M. D.,
Demonstrator of Chemistry.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- SYLVAN ROSENHEIM, M. D.,
Demonstrator of Bacteriology.
- ARCHIBALD C. HARRISON, M. D.,
Demonstrator of Anatomy.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Clinical Assistant in Gynecology.
- S. S. HOULTON, M. D.,
Demonstrator in Clinical Laboratory and Assistant in Diseases of Stomach.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- OTTO D. SCHAEFER, M. D.,
Assistant in Eye and Ear Diseases.
- JOHN MASON KNOX, JR., M. D.,
Demonstrator of Pathology and Physical Diagnosis.
- CHARLES B. CANBY, M. D.,
Demonstrator of Pathology.
- A. G. FREEDOM, M. D.,
Assistant in Diseases of Stomach.
- C. W. G. ROHRER, M. D.,
Assistant Demonstrator in Pathology.
- OTTO GLASER, A. B.,
Demonstrator of Embryology.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Issued Quarterly Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS
BALTIMORE.

Vol. V No. 1

APRIL, 1902

PUBLISHED AT
Baltimore and Eutaw Sts. Baltimore, Md.





GIVES BEST RESULTS

MULFORD'S ANTITOXIN



PHILADELPHIA, CHICAGO

H.K. MULFORD
COMPANY
CHEMISTS

Mulford's Glycerinized Vaccine

is prepared with every possible aseptic precaution. Each separate yield is subjected to the most rigid tests. It is guaranteed to succeed in 100 per cent. of primary cases, and retains its activity at least six months.

The virus from absolutely healthy animals only is employed, and each separate yield is subjected to the most rigid Physiologic and Bacteriologic tests.

H. K. MULFORD CO.

Chemists

PHILADELPHIA

CHICAGO

Case of 10 tubes—10 vaccinations—\$1.00. Mailed upon receipt of price. Write for literature.

The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,

CATONSVILLE, MD.

REFERENCES:

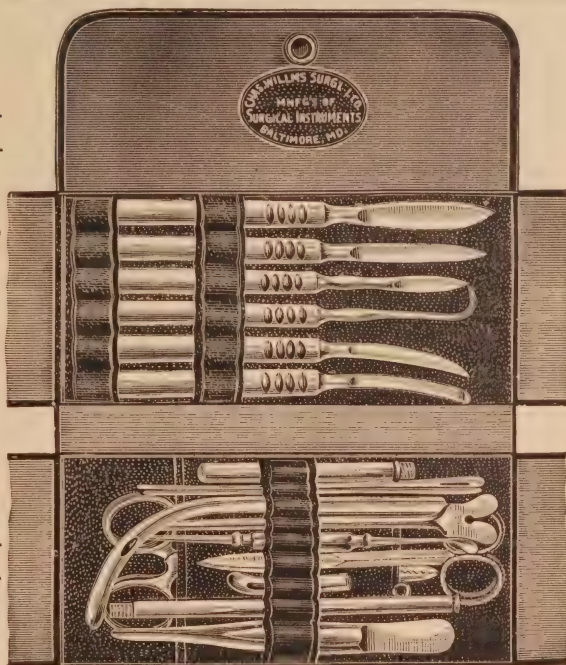
Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
Medicine and Surgery in Syria. DR. MILHIM N. HADDAD,	1
Syphilitic Retinitis. DR. HARRY FRIEDENWALD,	7
The Solution and Tincture of Ferric Chloride. DR. HARVEY G. BECK,	9
Smallpox. DR. S. WALTER WOODYARD,	15
A Case of Bronchopneumonia. D. WESTWOOD, REPORTER,	19
Spina Bifida. A REPORT OF TWO CASES BY DR. W. B. GRAVES AND DR. S. T. LOWRY,	22
Editorial,	25
Personal Notes,	31

**"OUR
LEADER."**

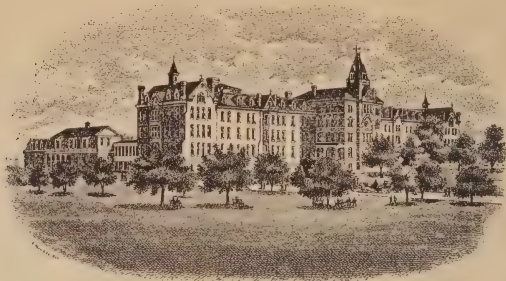
Have You
Seen it?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.



All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,
 BENJ. A. NELSON, General Manager,
MANUFACTURERS AND IMPORTERS,
300 N. HOWARD STREET, - - - BALTIMORE, MD.
 PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES.

ST. AGNES' SANITARIUM.



This Institution is beautifully situated on high, rolling ground, just outside Baltimore, and overlooking the Bay. It is thoroughly equipped as a modern Sanitarium for the treatment of Nervous Diseases and Drug Habits (no mental cases received). A complete Hydrotherapeutic Establishment has been recently added. Electric outfit, Gymnasium, Massage by trained operators, Sun Parlors, Billiard Rooms, Tennis, Golf, &c.

Medical Director, George J. Preston, M. D., Professor of Nervous Diseases, College of Physicians and Surgeons, Baltimore.

For further information, terms, &c., address

THE SISTER SUPERIOR,

St. Agnes' Sanitarium, Carroll P. O., Baltimore, Md.

CLINICAL LABORATORY OF Dr. CHARLES E. SIMON.

Private instruction in Clinical Chemistry and Microscopy; in Normal and Pathological Histology. Facilities for original work.

Examinations of blood, urine, stomach contents, feces, tumor specimens, etc.

Chemical and bacteriological examination of drinking water, milk, etc.

1302 MADISON AVE., BALTIMORE, MD.

A CARD.

At the beginning of another season, we beg physicians to consider the advisability of sending more of their patients to us for prescriptions and sick-room supplies. We will waive matters of ethics and base our claims for additional patronage upon the excellent character of our work, the better results secured through concentrated efforts and upon the advantages a comprehensive stock gives us.

**MICROSCOPICAL AND
CLINICAL SUPPLIES.**

HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

S. & D.'S HYPODERMIC TABLETS

were the first porous, and hence quickly soluble hypodermic tablets offered to the medical profession. Their high standard of excellence in solubility, uniformity and reliability has been maintained uninterruptedly since their inception. They have been frequently known as cold water tablets, because they dissolve faster in cold water than most others do in warm water, and it is generally admitted that they

ARE THE MOST SOLUBLE

hypodermic tablets offered the medical profession to-day. No watch is necessary to time their rate of solubility, as is the case with other makes, for they dissolve instantaneously. Merely drop a tablet into the syringe barrel, add some water and one instantaneous shake will be followed by complete solution.

SHARP & DOHME

BALTIMORE.

CHICAGO.

NEW YORK.

NEW ORLEANS.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap has been used exclusively in this baby's bath from birth, and her perfect skin and luxuriant hair excite wonderful interest and admiration.

AS A NUTRIENT SOAP
FOR THE SKIN

Resinol Soap

IS WITHOUT A
PARALLEL.

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.,
SYDNEY, N. S. W.
Agents for Australasia.



OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

MEDICINE AND SURGERY IN SYRIA.

By DR. MILHIM N. HADDAD, '97.

The word East is too big for the consideration of any subject, however limited it may be. Comprising vast territories and heterogeneous nations in different stages of growth and degeneration, it would be beyond the scope of any one article to discuss any subject as the writer would not be on even ground. However, in treating the subject of medicine and surgery the task is made somewhat easier, as the condition of these two important branches is almost the same all over the East, with, of course, the exception of Japan—that far eastern country, which shook off the lethargy of untold centuries, awoke from its death-like sleep into life and vigor, resumed its youth and activity, astonished anthropologists with the unparalleled strides she made in civilization, and from the dusty ruins of Asia she stepped into the stage of human affairs before the eyes of a wondering world.

One of the drawbacks in the East is that the physician or surgeon is consulted when the case is too far gone to yield to treatment, or that not much good is expected from operative methods. The morbid process, or often what is worse than that, the quack to whose lot the case had fallen commits his usual blunders in treating the case, ending often in unfavorable results, sometimes in fatal catastrophes. Then

comes the fatalism of a great number here, especially among fanatics, in whose case to resort to medical aid is to distrust, and in a sense, to interfere with the course of Providence.

Ignorance in the East is deep-rooted, very deep-rooted indeed, so that to talk to the masses of microbes and the part they play in the etiology and course of disease is like talking to them of the man in the moon. The above-mentioned reasons may be a sufficient explanation why it is often excessively difficult to cut short the course of a serious epidemic, or even to persuade the public to carry out hygienic rules.

Medicinal tradition also is an important factor. A herb which has been reputed in the days of Hippocrates to possess some medicinal virtue will, by the force of tradition, be used now-a-days in preference to our present active principles, whose medicinal properties and effects modern science places beyond dispute. For example, rose water dropped into an inflamed eye will be much preferred for soothing the pain to cocaine drops; pounded parsley placed over the bladder to any diuretic; cobweb or powdered coffee seeds to antiseptic applications, et cetera.

However, the light of science is by degrees shedding its rays into the dark and festering depths of Asia, and its awakening and resuscitating influence is felt everywhere. The new generation is beginning to be awakened into new life and vigor. Old superstitions and useless traditions are slowly but surely giving way to the irresistible tide of knowledge and to undeniable facts—prejudice having been replaced by investigation into the merits and truths of things, and fanaticism by a certain amount of toleration totally unknown to the old generation. The youthful and vigorous nations of Asia are advancing under the banner of the new civilization and the new science, while the decaying and degenerating countries will totter and fall to the ground forever.

The field of my practice is Shweir and its neighborhood, a part of the Lebanon some four thousand feet above sea level, full of pine and oak trees, with picturesque vines, wild valleys and corrugated hills. Sanneen, the highest peak of Lebanon, some ten thousand feet high, looks us right in the face with its white snow cap and invigorating breezes. The climate is of that cold, dry, bracing type not to be

excelled, perhaps, by any other part of the world. The hills of Shweir are all covered with pines, which send and spread their resinous odor miles away. With the Lebanon tops facing then to the east, and the blue Mediterranean waters lying only a few miles below them to the west, the hills make an excellent sanatorium, especially for tuberculous cases. During the past summer quite a colony of patients affected with tuberculosis flocked to these hills, and had a course of the open air treatment which in several cases had a markedly good effect. The place will, I believe, in course of time become a well recognized health resort for open air treatment, and we expect to have next year a crowd of tuberculous patients on our hills.

From time immemorial consumption has, in Lebanon and the East generally, been looked upon as an infectious malady. People avoided the company of such patients with scrupulous care, and continued to do so even when the state of medical science several years ago ridiculed this as an unnecessary precaution. In late years this tradition became so much rooted that consumptive patients, in the district where I reside, find themselves forsaken even by their nearest relations. The houses in which death from tuberculosis takes place are, as a rule, deserted, and the clothes of the patients kept untouched. Probably the propagation of recent medicine and its verdict on the malady as contracted by infection, and by infection alone, has had a great deal to do in exaggerating the fear of the people and deepening their long-rooted conviction from tradition.

Typhoid epidemics in this part of the country are a common yearly occurrence but the rate of mortality is exceptionally low. This may be owing to the healthiness of the climate and the strong constitutions of the natives. One fact worthy of remark in this connection is that the characteristic eruption is seldom met with, and its appearance is a rare exception. It is not easy to give a satisfactory explanation of this anomalous condition, but in all probability it might be owing to the modifying influence of the climate upon the vitality of the typhoid microbes. One of the striking incidents regarding the appearance of the rash took place in a case that was under my care some months ago. The patient was a girl about six years of age. She had an attack of typhoid without rash, and recovered. However,

owing to gross carelessness in giving the proper diet during convalescence the patient had a relapse, which when it got better ended in a second relapse. Strange to say, while the eruption was missing in the original attack and the first relapse it manifested itself in a typical manner in the second relapse. It is, however, satisfactory to note that the patient recovered.

Diseases from immorality are uncommon and syphilis is seldom met with. This latter disease is generally contracted while the patient has been temporarily staying at Damascus or Beyrout, or brought over from Egypt.

Diseases from intemperance, though occasionally met with, are also comparatively rare. The inhabitants, as a rule, are hard working people and lead a sober life with simple frugal habits. Consequently they have strong healthy constitutions, and the average length of life is longer than that of crowded towns and fast living countries.

Owing to the above-mentioned facts, and the excellent condition of the climate, surgical cases have exceptionally favorable results. Operations which no surgeon undertakes in a town except in a hospital, are performed here in the homes of the patients, and with issues that perhaps compare favorably with those done in hospitals. Both erysipelas and gangrene are rare, and the natural courage and fortitude of the inhabitants tend to lessen the effects of the shock. When an operation is decided upon, the patient generally submits to it with calm resignation and even good humor. To give an illustration of the natural courage of these mountaineers I would mention the case of a young man who, meeting with an accident which crushed the greater part of the leg, drew his knife and with his own hand severed the tendons and skin with which the leg was still hanging and threw it away to a distance.

Bone necrosis and caries are uncommon, so are also eye diseases except simple conjunctivitis and occasional cases of purulent ophthalmia and granular eyelids. The primary cases met with here are in all probability imported from the neighboring towns, where the affection is rather common. Owing to the temperance of the people and the coolness of the climate, liver affections are rare.

Malaria is very prevalent all over the country, but is very amenable

to a short course of quinine, and it rarely assumes a chronic character. Cases of very severe and obstinate nature ending in liver, renal and heart complications with subsequent death are sometimes met with. But most of these cases are generally contracted in places where malaria is very common and malignant, and where the patient resides for a considerable length of time before returning home. The most prominent among these places is the lake Huleh—the old lake called the Waters of Merom in the Bible. Malaria contracted in these regions is of a very virulent type, and if the patient is compelled to make a lengthy stay there, irreparable damages and destructive results are the consequences.

We have had lately several epidemics of influenza, but the disease has not here the same dread results it has in Europe and the United States. The rate of mortality is very low, and dangerous complications are rarely seen. Dengue fever is also a frequent unwelcome though not a dangerous visitor; once it favors a place with a visit it lays hold of almost all individuals and leaves them in exhausted condition, but its effects are evanescent and I know of no case which ended fatally.

Diseases of respiratory system are of common occurrence, especially during the winter season when the cold southeast winds are prevalent. Owing to their being poorly clad the lower classes suffer greatly from bronchitis, pneumonia and pleurisy. But a good number of the latter cases must be attributed to tuberculous origin when they are unjustly attributed to the direct effects of cold. Tuberculosis is more common than what one would at first suppose, and despite the excellent condition of the climate almost all such cases end in death; while this may be at first sight looked upon as detracting from the beneficial results of the open air treatment, it, I believe, in fact, tends to support it. No matter how excellent the condition of the climate may be, indoor life is fatal to tuberculous cases, and no benefit can be derived from the pure and invigorating environments of the patient unless he avail himself of open air treatment.

Eruptive fevers are prevalent all over the country except scarlatina which was totally unknown in Syria and Lebanon previous to the last ten years. Medical men practicing here used to know it only

by name, just as they know yellow fever, for example. The first appearance of scarlatina in this part of the world took place in Palestine, where it was imported by the Jews, who emigrated from Russia during the time of their expulsion from that country, and other parts of Europe. Since then the epidemic spread over a great part of Syria and Lebanon, and we here were visited by it last summer but not much harm was done.

Vaccination is the rule all over the country; parents are very anxious to get their children vaccinated at an early age. Despite these precautions we occasionally get epidemics of smallpox, which sometimes spread over a considerable area.

Owing to the reluctance of people here to get properly trained medical men to care for women during labor, midwifery is in a sad and deplorable condition. If the doctor is ever called it is usually when the case has reached a hopeless condition, especially in cases of retained placenta. I had a case of the latter condition when the placenta had been retained for three or four days and septicemia commenced before I was called to the patient; needless to say that the case ended fatally. Cases of metritis, endometritis, prolapsus and deflection of the womb are usual consequences of badly-delivered women. If the constitution of the latter is not exceptionally strong the consequences would be far more serious. I might mention one or two cases of the rough and brutal treatment parturient women sometimes receive at the hands of ignorant midwives. I was called the other day to a case in which the placenta was retained and the midwife pulled it by the cord so roughly that she caused inversion of the uterus. I returned it carefully and the case got better. In another case a friend of mine arrived at a labor case just in time to prevent the ignorant midwife amputating the prolapsing uterus, as she thought it a morbid growth.

Most remarkable and astonishing to the civilized world is the easiness with which Bedawin women give birth to children. Some of them are delivered on the way-sides without the aid of anybody, then walk off with their new-born babies with the greatest ease and comfort as if nothing was the matter with them.

We hope that as time goes on the people may take a more rational

view of medical matters and the progress which has started will continue. We are indeed much better off now than a few years ago and have every reason to believe that the future holds in store great things for medicine in the East.

Shweir, Mt. Lebanon,
Beyrout, India.

SYPHILITIC RETINITIS.

By DR. HARRY FRIEDENWALD, '86.

One form—of rare occurrence—has recently been under the observation of the writer. His purpose in publishing the case is to direct attention to a disease which has been much neglected.

Mr. H. D., white, aged 38, entered the Baltimore Eye, Ear and Throat Charity Hospital May 3, 1900.

History.—Family history negative. Had ordinary diseases of childhood, and had vesical calculus three years previously, of which he was relieved. Otherwise enjoyed good health until May, 1898, when he contracted syphilis without marked secondary symptoms. In November, '99, he had a severe attack of iritis in the right eye. In January, 1900, the left eye became affected, the trouble gradually increased, and, in April, the sight of this eye was almost entirely lost.

Stat. Praes., May 3, 1900. Right eye pupil small and bound down by numerous synechiae. Ophthalmoscopic examination impossible. Left eye, a few synechiae, pupil easily dilated; ophthalmoscopic examination reveals a clear papilla, but a number of small white spots in the macular region and also below the papilla. The fovea is occupied by a somewhat larger white spot. At a point some distance below the papilla there are faint traces of old choroiditis. One large branch of the superior nasal artery is markedly sclerosed, appearing as a white line. Vision of right eye fair, that of the left eye very bad, reduced to counting fingers held close by.

The left eye suggested the appearance of albuminuric retinitis. But the urine was normal. The patient was given vigorous specific treatment, including injection of bichloride of mercury in the gluteal region.

May 10. The condition of the left eye has changed greatly since

the first examination. There is now much vitreous opacity, which partly obscures the papilla. There are also numerous small and very white spots arranged in groups along the inferior temporal vessels, similar to the spots previously described, in the central portion of the retina. In the macula there is one large white spot, around which numerous small spots are arranged. There are also many small white spots near the temporal edge of the disc, and near the upper margin of the latter there is one large white effusion. The nasal portion of the retina also contains many small white spots.

A number of large hemorrhagic spots have made their appearance along the course of the superior nasal vessels.

The pupil of the right eye, though still bound down at many points, is sufficiently dilated to admit of ophthalmoscopic examination and the fundus is found normal.

May 22. The retinal spots appear to be clearing up.

May 29. The condition has improved greatly. R E V = 20/70; L E V = 20/200. The patient is taking large doses of iodide of potassium.

Sept. 8. The patient was allowed to spend several weeks in the country and returned greatly improved. The retinal spots have entirely disappeared. He is readmitted to the hospital. The treatment with iodide of potassium is continued.

Sept. 21. Last examination. The left papilla appears very pale, but not decidedly atrophic, and is somewhat obscured by vitreous opacity. There is a large number of fine extravasations of blood in the inner upper portion of the retina. The sclerosed vessel, described above (and frequently seen), cannot be found. All the vessels in the superior nasal region of the retina are either exceedingly fine and attenuated or have disappeared entirely. Along the course of the inferior nasal vessels there are a number of small unpigmented choroidal patches. The white spots in the macular region and near the papilla have disappeared without leaving a trace of atrophy or of disturbance of the pigment.

There are many fine and coarse opacities in the anterior portion of the vitreous.

The right pupil is still very irregular, the left is perfectly round.

The color of the right papilla is decidedly pinker than the left. The right fundus is normal.

Vision has improved to almost normal in the right eye; that of the left eye is about $\frac{2}{8}$. The field of vision of the right eye is perfect; the field of the left is very defective. The lower part of this field is almost entirely lost, and from the shape of the defect it is evident that the cause is a disturbance of the vascular supply.

The patient now left Baltimore to return to his home in the South, and a later report received from him was very favorable.

In this case we have the occurrence of severe iritis in the right eye, followed by a mild attack of iritis in the left; this attack is associated with slight choroiditis and marked retinitis. It is scarcely necessary to point out the reasons for regarding this as a case of syphilitic retinitis. Not only were the spots in the retina of the characteristic appearance of retinal lesions, but they disappeared without leaving a trace of pigment atrophy, which is always the vestige of choroiditis. Besides this there was marked evidence of vascular disease of the retina. It is true that there was some choroiditis previous to our first examination, and perhaps during the attack of retinitis, but the slight evidences of choroidal atrophy indicate that this was relatively very unimportant in comparison with the retinal affection.

The angiosclerosis observed in this case is noted in many others published, a fact which lends weight to the view that syphilitic retinitis is due to endo- and perivasculitis.

The period intervening between the infection and the outbreak of retinitis was almost two years. This is in accord with the cases hitherto described.

THE SOLUTION AND TINCTURE OF FERRIC CHLORIDE.

By DR. HARVEY G. BECK, '96.

In the whole history of mankind there is found no other metal upon which depended the progress and civilization of nations as much as that of iron. Its prominence in the arts as well as in medicine gives it a universal recognition. Therapeutically it has been em-

ployed for 3300 years. To-day it comprises a larger area in the field of medicine than any of the other mineral elements.

Owing to the many preparations of iron, but two will be subjected to investigation, namely: The Tincture of Ferric Chloride which has been used for many years, and the Solution of Ferric Chloride which recently became the source of the tincture. These will be considered together, not with the object of presenting new methods or formulæ, but to properly investigate the merits and demerits of the U. S. P. formula, to study the relationship existing between the solution and the tincture, and to determine the value of the various productions as obtained by this method.

Ten carefully selected samples of solution of ferric chloride appear in Table I, showing specific gravity, percentage of ferric chloride, percentage of hydrochloric acid and the presence of nitric acid or ferrous salt; twelve samples of the tincture subjected to similar analyses, save that the test for free hydrochloric acid was omitted, gave results as shown in Table II.

TABLE I.
EXAMINATIONS OF SOLUTION OF FERRIC CHLORIDE.

Sample No.	Percentage Fe_2Cl_6	Percentage free HCl	Specific Gravity.	HNO_3	Ferrous Salt.
1.....	37.46	1.29	1.397	slight.	none.
2.....	37.57	.85	1.399	slight.	"
3.....	36.20	2.03	1.387	decided.	"
4.....	37.85	1.04	1.405	slight.	"
5.....	38.83	1.41	1.406	much.	"
6.....	38.41	.00	1.402	much.	"
7.....	35.82	.60	1.367	much.	"
8.....	38.71	1.35	1.407	slight.	"
9.....	34.82	3.19	1.386	trace.	"
10.....	33.83	.84	1.340	none.	much.
Average	36.95	1.26	1.390		

Three of the samples, Nos. 6, 7, and 10, were made by retail pharmacists; all the rest were made by manufacturing chemists. All the necessary precautions were taken in ascertaining the specific gravity. Anhydrous ferric chloride was determined by the process given in the Pharmacopœia of 1880, namely: 10 grams of the solution were precipitated with an excess of water of ammonia, well washed, dried and ignited, and weighed as ferric oxide.

The plan adopted for the determination of free hydrochloric acid deserves special notice; and the consideration will, therefore, be deferred until later.

Observe in the preceding table the approximate relationship existing between the specific gravity and the percentage of anhydrous ferric chloride, also that in most cases it is nearly in proportion to that of the U. S. P. Solution No. 4, is practically normal in specific gravity and Fe_2Cl_6 . No. 10 is lowest in specific gravity, containing also the lowest percentage of Fe_2Cl_6 , yet corresponding almost proportionately to No. 4 or the official. Then again, by taking the average of both columns we have for specific gravity 1.390, and for Fe_2Cl_6 , 36.95 per cent, and again the proportion corresponds practically to that of the official—37.8 per cent.

The average of Fe_2Cl_6 is .85 per cent below that of the official, which would imply a good collection of samples; but when the extreme variation is observed to be 5 per cent, this would at once indicate some weakness and imperfection in the process, which is to be attributed to the later part in which the U. S. P. directs after effervescence, etc., add enough water to make a certain definite weight. If pure iron wire is used, hydrochloric acid containing 31.9 per cent of absolute acid, sufficient time allowed for complete reaction, the tests for nitric acid, ferrous salt and oxychloride cautiously applied, and the work carefully manipulated, it will result in a reliable product. But the iron is not always pure, hydrochloric acid is often of indefinite strength, the reaction not always completed, besides taking into consideration the liability to error in applying the tests, and the manner in which the work is generally conducted; hence, the process will not result in products of uniform strength. If, instead of diluting the solution to a definite weight, it be diluted to a definite specific gravity, we then might disregard slight impurities in iron or HCl , or other sources of errors likely to be encountered, and secure decidedly better results.

Another noteworthy fact in connection with the table is this: Had the solution with a specific gravity below that of 1.405 been evaporated, and those containing a higher specific gravity, further diluted so that they would all conform with the official in specific gravity, the

percentage of Fe_2Cl_6 would vary only about 3 per cent. The fact above-mentioned with others involved in the table, forcibly impresses some excellent advantages over that of the official method.

The Pharmacopœia directs free hydrochloric acid to be present in the solution of ferric chloride, but does not furnish a method whereby the amount contained may be determined. The U. S. P. assay for anhydrous ferric chloride is not in itself sufficient to insure the quality or standard of the preparation. Every physician is familiar with the fact that the medicinal qualities in a measure depend upon the quantity of hydrochloric acid present. When deficient it reduces the percentage of iron and deprives the tincture made therefrom of the ethereal odor, and when added in excess it becomes deleterious inasmuch as it affects its therapeutic properties. References have been made to various works and text-books on chemistry with a view of finding some satisfactory method for making this determination, but with unsatisfactory results; in consequence of which a new and original method (suggested by Prof. W. Simon) was employed, which proved to be very simple and accurate. The method is as follows:

Take 1.0 gram of the solution, dilute with 100 cc. of water, neutralize with seminormal solution of potassium hydroxide, using litmus as an indicator, transfer it into a flask and add enough water to make 250 cc. Titrate 50 cc. of the supernatant liquid with decinormal solution of silver nitrate, after the addition of a few drops of neutral potassium chromate. From the number of cc. of silver nitrate solution required, determine total amount of hydrochloric acid present. From the percentage of Fe_2Cl_6 ascertained previously calculate the amount of absolute acid represented, and deduct from the total; the result will be free acid present. In case an excess of KOH solution is added, titrate back with sulphuric acid solution.

The official solutions should contain 27.43 per cent of hydrochloric acid, allowing 1.95 per cent for free acid. It will be readily observed that the solutions are generally deficient in hydrochloric acid. This is due to a weaker acid than the official being used in making the preparation, causing considerable oxychloride to be formed during the process, which is not always detected. The 5 per cent of official acid, directed to be added, is partly taken up by the oxychloride,

thereby reducing the amount of free acid. The excess is accounted for by reason of insufficient time allowed for the acid to act on the iron. Nos. 3 and 9 are examples of the latter. The percentage as stated in the column is absolute acid.

Prior to the publication of the Pharmacopœia of 1870, tincture ferric chloride was made either directly from iron wire or from the subcarbonate of iron. The pharmacopœial directions of 1850 were: "Pour the acid upon the subcarbonate of iron in a glass or porcelain vessel, mix them, and when effervescence ceases, apply a gentle heat and continue it, stirring occasionally until the carbonate is dissolved, then filter the solution and mix with the alcohol." This formula did not provide for an excess of acid, consequently precipitation was apt to ensue; particularly did this objection prevail when inferior acid was used. Tinctures made by this process are very unreliable and of indefinite strength. Incessant complaint of the imperfection of the formula resulted in the adoption of a new and much improved method in the Pharmacopœia of 1860, as proposed by Dr. Squibb and published in the American Journal of Pharmacy, 1857, p. 290. Pure iron wire was substituted for the subcarbonate. The official directions were: "When effervescence has ceased drop in nitric acid, constantly stirring until it no longer produces effervescence. Lastly, when the liquid is cold, add sufficient distilled water to make it measure a pint and mix it with alcohol." This yielded a tincture which contained a little nitric acid, and all the nitrous acid the iron solution was capable of holding at a temperature near the boiling point. It is claimed that such a tincture has, in six months or a year, a full ethereal odor in which ethyl nitrite is recognizable.

The 1870 Pharmacopœia again modified this formula; the two steps in the process were separated and two distinct preparations introduced, one an acid solution of ferric chloride, the other the tincture which was made from the solution.

The committees on revision of 1880 and 1890 continued this plan. Our present official directions are: "After effervescence has ceased apply heat by means of a sand bath, until the liquid is free from nitrous odor." This solution yields, after being mixed with a definite quantity of alcohol and allowed to stand for three months, the official

tincture of ferric chloride. This tincture does not possess much more than a trace of ethereal odor. The reaction between the acid and the alcohol is very slow, and the portion of acid small that enters into combination with the alcohol in forming ethers in course of three months. Therefore, the U. S. P. directs it to stand three months, although it is preferable to stand a year. The ethers formed possess diuretic properties. Comparatively few pharmacists comply with that part of the process where it is directed to stand three months; accordingly such products are deficient in diuretic properties.

When the samples were collected one store was found to be out of the tincture entirely. The proprietor immediately proceeded to supply my wants with an extemporaneous preparation. The general public might take pride in securing a freshly prepared article, but it surely is not what should be expected by those knowing its properties.

The following table gives the results of a comparative analysis of the tincture as found in the retail store:

TABLE II.
EXAMINATIONS OF TINCTURE OF FERRIC CHLORIDE.

Sample No.	Specific Gravity	Fe ₂ Cl ₃ Per Cent.	Parts by Weight of the Solution used in making the Tincture.	Made from Solution Number	HNO ₃	Ferrous Salt
1.....	.900	13.15	35	1	0	slight
2.....	.987	10.00	26.6	2	0	slight
3.....	.972	11.52	....	....	0	0
4.....	.980	13.80	....	....	0	trace
5.....	.980	13.33	....	....	trace	0
6.....	1.028	17.09	45	4	slight	0
7.....	.927	10.25	28.6	7	0	decided
8.....	.948	11.50	....	....	slight	0
9.....	1.032	11.31	....	....	0	much
10.....	1.031	12.68	33.6	6	0	much
11.....	1.030	10.71	29	3	trace	0
12.....	.972	13.03	....	....	much	0
Average .....	.989	12.36	....	....	....	....

All the samples were collected before the introduction of the new Pharmacopœia, and should, therefore, contain 13.25 per cent of anhy-

drous ferric chloride and have a specific gravity of .980. The new Pharmacopœia has modified the formula for making the tincture somewhat, altering the specific gravity and percentage of anhydrous ferric chloride.

No relationship exists in above table between specific gravity and percentage of ferric chloride, as in Table I. Compare the average of the two columns and observe that the specific gravity is above that required by the U. S. P., whilst the percentage of ferric chloride is below. Solutions Nos. 9, 10 and 11 having the highest specific gravity are almost inversely proportioned in value of ferric chloride. Such dissimilarities may be due to various causes. The specific gravity is dependent upon the amount of ferric chloride present, the quality of the alcohol, and in some instances to water which has been fraudulently added. By a simple calculation the parts by weight of the solution used in making the respective tincture by the retail pharmacist can be ascertained from the results obtained by the analyses.

A tincture made with a deficient amount of solution of ferric chloride yet retaining its specific gravity, or as in many instances is materially increased, is evidence of the fact that water has been added. It may, therefore, be assumed that all tinctures having a specific gravity above that of .980 and a percentage of ferric chloride below that of 13.25, contain a certain amount of water in substitution for alcohol. Nos. 2, 9, 10 and 11 are examples of this class.

SMALLPOX.

By DR. S. WALTER WOODYARD, '91.

It seems that this is an opportune time to study this much dreaded disease, since there is such a prevalence of it throughout the entire world—any one of us is likely to be called upon any day to make a diagnosis of smallpox. In this paper I cannot produce anything new, but hope to say something to freshen our memories about this subject; especially do I wish to dwell on the character of the present epidemic, the life history of which is identical with that of the more fatal forms—an incubation of 12 to 14 days, a period of febrile invasion lasting three or four days, the fever-curve showing from 101 to

105 degrees, during which time there is experienced pain in head, back and limbs. Nausea and vomiting often accompany the period of invasion and a chill generally serves to usher in the attack. On the third or fourth day the eruption begins to appear and the temperature drops to normal. In three of my cases the eruption was preceded by a scarlet-red rash. The eruption appears first on the forehead and inner surface of the wrists and forearms as small red spots. From here it spreads rapidly to other parts of the body, so that at the end of twenty-four hours the distribution of the eruption can be ascertained. Forty-eight hours later the eruption has passed through the papular stage, in which the characteristic shot-like feel might serve alone to anticipate a diagnosis. The sixth day finds opalescent papulovesicles, light yellow at the top, from a collection of serum, and these rapidly become purulent; with this change there is a settling down, flattening process in each and an umbilication of the center. In very mild cases the umbilication may not be seen. The umbilication can be seen most plainly from the eighth to the tenth day of the eruption, after which the pustule assumes a form rounded and globular from distention.

On the occurrence of pus the temperature again rises and remains from 24 to 48 hours.

The eruption as to site is a universal one, including the palms of the hands and the soles of the feet, showing first on the forehead and inner surfaces of the wrists and forearms, and diffused most thickly over head and face. The eruption is a symmetrical one, appearing first as discrete red spots which rapidly become elevated, forming papules of beefy-red color, varying with the complexion of the different patients. The apex of these papules is rounded, the base not infiltrated and they are of so firm consistence that they feel like shot beneath the skin.

The progress from the papular stage is with such great uniformity that 48 hours shows the papules to be transformed into vesicles with clear summits and their roofs gradually flatten out and the walls allow a cupping of the center of each vesicle. Around the base there appears a trifle of induration, and an areola of a reddish color. The change from a vesicle to pustule gives to it a greyish-white color, the

walls loose their flaccidity and the roof its umbilication, producing a lesion that is larger than the original papule, finally becoming a typical pustule. When not disturbed the pustule, about the 9th or 10th day of the eruption, begins to dry up and a greyish-brown crust or scab is formed, which in four or five days can be completely removed. Pitting depends on the severity of the disease, and in a majority of cases Sydenham's assertion that "discrete smallpox rarely leaves its mark" holds true. With proper precautions a transient stain will be the only remains in mild cases. These stains, or post-eruptive lesions, independent of pitting, remain a variable time. On the disappearance of the crusts or scabs the stains are of a salmon-pink color, getting darker after a few days, very noticeable on exposure to cold, showing then as a bluish-black through a thin and slightly corded area corresponding to the base and areola of each separate eruption.

The only disease that is likely to be confounded with a mild case of discrete smallpox is chickenpox. However, when we remember that chickenpox is a disease of childhood this mistake should not be made. I admit that we exceptionally have a case of chickenpox in the adult, but it has never been known to be epidemic in the adult. I have found no better authority on the differential diagnosis of smallpox and chickenpox in the adult than Dr. A. H. Doty, Health Officer of the Port of New York, and I quote him at length. He says: "In smallpox the eruption appears as circumscribed hyperæmic areas, the margins of which are very sharply defined, and which involve the true skin to considerable depth and gives to the eruption in the early stages the sensation of a shot placed just beneath the surface of the skin. This tense and hard condition naturally disappears as the papular and vesicular stages are succeeded by the pustular. The eruption in chickenpox is in marked contrast to that just given. The vesicles are very superficial and only slightly involve the true skin. They contain either a transparent or a pearly-hued fluid, and are soft and pliable and can be easily detached and are short lived. It is of great importance to fix in mind the superficial character and tenderness of the chickenpox vesicles. In appearance they resemble small blisters.

"In smallpox the eruption presents itself in one crop, i. e., it passes through the different stages practically together as papules, vesicles and pustules. When the eruption is complete secondary crops never appear. Too much importance cannot be given to this sign, as none other more closely approaches that of a pathognomonic character. The manner in which the eruption of chickenpox appears is diametrically opposite to that of smallpox, inasmuch as it notoriously comes in successive crops. Alongside of vesicles which have dried down with the formation of a dark scab, we find small tender vesicles just appearing. This is so strikingly apparent that it can hardly be overlooked even in a superficial examination. Moreover, the eruption of chickenpox appears abruptly as vesicles, and is not preceded by papules as in smallpox."

The distribution or location of the eruption has a practical bearing in the diagnosis of discrete smallpox from chickenpox. To bring this at once to its important practical application I again quote Dr. Doty: "In smallpox, even in mild cases, the hands and feet are to some extent almost always involved; whereas in chickenpox, even with a profuse eruption, the hands and feet are either unaffected or have but little eruption. The appearance of hard, tough, circumscribed and distended papules or vesicles on the hands and feet, particularly on the palms and soles, is an exceedingly important diagnostic sign of smallpox. In chickenpox the hands and feet are often singularly free from the eruption even when it is profuse on other parts of the body, besides the eruption does not often appear on the palms of the hands and the soles of the feet." There should be no mistake in differentiating these two diseases when we know—

1st. The character of the eruption.

2nd. The manner in which the eruption appears.

3rd. The distribution or location of the eruption.

To quote Doty again: "Under all circumstances it should be borne in mind that the diagnosis of smallpox and chickenpox is made from the appearance of the eruption."

Regarding the advisability of calling this mild type of smallpox—for such it undoubtedly is—a modified smallpox, there is little to say. It certainly is not varioloid, for by this we mean smallpox modified

by vaccination, and of the 57 cases we have had in Greene county not one of them had previously been vaccinated. We have nothing more or less than a mild type of disease, such as may occur at times with other infectious diseases. We cannot be too careful in dealing with the present general epidemic of smallpox, and those who have failed to make a correct diagnosis, or who are seeking notoriety by suggesting a new name for an old disease can do much toward aiding in the suppression of the trouble by admitting their errors, or at least cease preaching false doctrine.

Greeneville, Tenn.

A CASE OF BRONCHOPNEUMONIA.

D. WESTWOOD, '02, REPORTER.

J. G., male, aged 32, sailor, was admitted to the City Hospital October 2, 1901, died October 11, 1901.

Family History.—Cannot get it, patient unconscious.

Past History.—Cannot get it, for above reason.

Present Illness.—Patient was brought to hospital in an unconscious condition, having had a convulsion much resembling epilepsy. His blood and urine were at once examined. The blood showed no malarial organisms but did show one or two hyaline bodies. The urine proved to be normal. Temperature on admission, 102°; pulse, 110; respirations, 24. Quinine gr. xl was given hypodermatically.

Physical Examination.—Patient unconscious. Breathing loud and stertorous. Skin and lips dry, tongue coated brown and shows fresh wounds from biting.

Chest.—Fair sized, slight depressions above and below both clavicles.

Percussion.—Both sides chest sound about normal.

Auscultation.—Many moist râles over both sides of chest anteriorly and posteriorly.

Heart.—Rather rapid in action, and the sounds cannot be distinctly heard on account of the loud breathing.

Arteries.—No sclerosis, they seem about normal.

Abdomen.—Somewhat flattened in appearance; a few hyperemic papules noticed over abdomen, rather suspicious of rose spots. Slight rigidity of abdominal walls.

Liver.—Area of dullness normal.

Spleen.—Not palpable.

Reflexes.—Normal.

Oct. 3. Temperature this morning 102° , pulse 80, respiration 24. This A. M. the patient had another convulsion; his eyes were deflected upward and to the left. His tongue shows fresh wounds from biting. During last night he was very restless, and voided his urine and feces in bed.

Treatment.—Bath when temperature 102.5° . Liquid diet. Ice bag to head. Nitroglycerin gr. $\frac{1}{100}$ every 3 hours.

Blood Examination.—Widal negative. Malaria negative.

Blood Count.—Reds normal. Leucocytosis 31,000. Polymorphonuclear neutrophiles greatly increased.

Oct. 4. Temperature this morning 96° , pulse 84, respirations 20. Yesterday afternoon patient was covered with a profuse perspiration; his breathing was loud and stertorous, and some rigidity of body was noticed. His temperature last night reached 105° , pulse 160, and respirations 25. He was given a tub bath. Patient during all night was noisy and unruly in his delirium. This morning he is quieter and takes food from a spoon.

Oct. 5. During the afternoon yesterday patient's temperature reached 103° , pulse 100, respirations 28; he was very delirious all night. This morning his temperature is 97° , pulse 76, respirations 20. He is quieter and shows some signs of consciousness. Patient is now kept tied in bed and he resists any attempt made to examine him. His face is flushed, conjunctiva injected, pupils equal. Lips dry and parched. Gums and teeth covered with sordes. Tongue dry and coated. From appearances right side of chest does not expand as freely as left side. Left lower costal margin somewhat bulging and left side chest slightly more resonant. Many moist râles heard all over front of chest. Cannot examine chest posteriorly as patient resists and disturbs whole ward.

Oct. 6. Temperature this A. M. 99° , pulse 88, respirations 20. No particular change from yesterday. Patient restless and delirious; still tied in bed. He seems rather vicious in his delirium; passes urine and feces in bed.

Oct. 7. Temperature 98.3° , pulse 82, respirations 20. Patient about the same as yesterday. He is very delirious and noisy.

Oct. 8. Temperature, pulse and respirations normal. Yesterday afternoon the nitroglycerin was discontinued and morphia was given; also quinine and phenacetine aa gr. ii. Last night patient was quieter. This morning there is a discharge from right ear. Have examined a specimen under microscope and can find no organisms. Orders to wash ear with warm boracic acid solution.

Blood Examination.—Widal negative. Malaria negative.

Blood Count.—Reds 5,500,000. Leucocytosis 24,500. Managed to get some sputum from patient this morning. It is thick, tenacious, of yellowish green color. Stained specimen shows streptococci, staphylococci and numerous large pneumococci.

Oct. 9. Temperature, pulse and respirations normal. Patient is still delirious but seems to be weaker. Takes his nourishment from spoon. Ear not discharging. Do not notice so many râles in chest. Heart action weak. Pulmonic second sound accentuated. No murmurs.

Oct. 10. Temperature 97° , pulse 101, respirations 28. Patient this morning seems very weak. His face is moist and his appearance is that of a very sick man. Lips very dry and show abundant herpes. Tongue dry, coated and covered with sordes. Heart action weak, pulse rapid and wiry. He is not noisy and for the first time did not resist my examining him. He also understood and paid attention as to what was said to him. Will protrude his tongue or turn his head when asked to do so.

Oct. 11. Pulse 106, temperature 97.3° , respirations 56. This morning patient seems to be in a dying condition. Limbs cold. Pulse weak, rapid, and hardly perceptible. Respirations very rapid and shallow. Eyes fixed, pupils dilated, mouth open.

Oct. 11. Patient died at 12.30 P. M.

Diagnosis.—Pneumonia with dominance of nervous symptoms.

NECROPSY.

Oct. 12. Body length 165 cm. Weight 140 pounds. Pupils 4.5 mm. Man of average build, well nourished. Rigor mortis and post-mortem lividity. Not marked. External inspection negative.

Abdominal Cavity.—Position of viscera uniform. Surface of intestines moist. Appendix 5 cm. in length, tip toward spleen. Intestinal tract normal. No irregularities. No ulcerations. Mesenteric lymph glands enlarged. Liver, normal. Bile duct, patulous. No gall stones. Spleen, normal. Capsule shrunken, due to fluids. Pancreas, normal in consistence, size and structure.

Chest Cavity.—Heart and great vessels, normal. Valves good. No excess of fluid in pericardial cavity. Lungs show bronchopneumonia. The smaller bronchi and some of the air cells are filled with the products of bronchopneumonia. Small abscesses noticed. Lower lobe, left lung, partially solidified, beginning of red hepatization. Both pleura adherent. Kidneys, normal. Bladder contains cloudy urine, flaky, due to desquamated epithelial cells, one of the early signs of decomposition. Seminal vesicles, swollen and full of fertile semen. Prostate, transverse diameter increased. Weight 20.5 grams.

Anatomical Diagnosis.—Bronchopneumonia. Beginning consolidation of lower lobe, left lung. Microscopical sections made of lung, liver, spleen and kidney.

Lung.—A large number of the air cells are filled with pus corpuscles. Other areas of lung tissue are normal.

Diagnosis.—Bronchopneumonia. Liver, normal practically; slight congestion of capillaries. Spleen shows congestion, capsule thicker than normal. Kidney, normal.

SPINA BIFIDA.

A REPORT OF TWO CASES BY DR. W. B. GRAVES, '01 AND DR. S. T. LOWRY, '01.

CASE I.—On Sept. 8, 1901, Mrs. B——, a multipara, after a perfectly normal labor gave birth to a female child. Upon examination the infant was found to be well nourished, weighing 8 lbs. and measuring 49 cm. in length. Upon observing the back of the child there

was discovered just over the lumbar vertebæ, a sessile tumor, measuring transversely 4 cm. and longitudinally 4.5 cm. or about the size of a large English walnut. The base of this tumor was covered with apparently healthy skin, which extended up from the lower side of the growth towards the fundus for about 2 cm.

A thin epidermis, which was perfectly translucent, and through which could be seen a straw colored fluid and a portion of the spinal cord, covered the fundus. Aside from this one defect, the child was perfectly normal in all respects. There were no signs of club-foot, hydrocephalus, rectal or vesical paralysis or other kindred affections, which so commonly accompany cases of spina bifida.

Upon palpitation around the edges of the gap in the vertebæ, it was determined that the opening in the bone did not extend completely through the bodies of the vertebræ, but was limited to the arches and spinous processes, which condition is decidedly most common in these cases.

With the above observations, together with the following signs and symptoms a diagnosis of spina bifida was made:—1. The tumor was congenital and occupied a central position just over the lumbar vertebræ.

2. The size of the tumor could easily be diminished by gentle pressure, thus at the same time increasing the tension of the anterior fontanelle; however, as is frequently the case, no stupor, convulsions, or other nervous phenomena followed this pressure upon the tumor.

3. When the infant cried a very noticeable bulging of the tumor was apparent.

There was a gradual though slight increase in the size of the tumor until the 3rd day after birth, when the sack ruptured permitting a portion of the fluid contents to escape. Up to the present time a small sterile pledget of cotton, held over the tumor by a loosely fitting gauze bandage, has been the treatment; the appearance of the tumor has not materially changed and the infant is to all appearances in good condition.

CASE II.—The mother in this case like the one in the first case cited, was a multipara and her labor was normal in all respects. The

child a male, was only fairly well nourished, weight 6 lbs. 6 oz., length 50 cm.

On examination there was found over the sacrum a tumor measuring 5 cm. longitudinally and 3.5 cm. transversely; the sack had ruptured before birth and most of the fluid contents had escaped. The base of the tumor, as in Case I, was covered with healthy skin; however, over the fundus the epidermis was thicker and consequently not as translucent as in Case I. After the 6th day the small opening in the sack seemed to have closed and a small amount of fluid began to accumulate, thus slightly increasing the size of the tumor. On the 3rd day clonic and tonic spasm set in and continued until the 6th day at intervals of about every four hours. After the 6th day a decided stupor was present and it was with the greatest difficulty that nourishment could be given. The infant continued in this condition until the afternoon of the 11th day, when it died.

Unlike Case I, there accompanied the spina bifida in this case a typical double-equino varus; the anterior fontanelle was also much larger than is usual.

The prognosis in all cases of spina bifida may be said to be exceedingly grave, a fatal termination of the case is the rule and recoveries are rather the exception. In well nourished infants where the tumor is small and is covered with healthy skin, and has no tendency to grow rapidly, a more favorable termination may be anticipated; however, in the great majority of cases death usually ensues as a result of marasmus or septic meningitis.

As regards treatment, operative procedure is possibly the most successful method of dealing with these cases. Bayer who has carefully reviewed the subject, takes the position that the condition is one analogous to hernia and should be treated as such; a detailed description of his operation may be found in any late work on surgery.

Where the tumor is not large a piece of sterile raw-cotton may be placed over the tumor and held in place by a loose fitting bandage, the cotton may be dipped in collodion before it is applied.

The injection into the sack of Morton's fluid is recommended and has a number of advocates.

WILLIAM S. GARDNER, M. D., EDITOR,
1012 McCulloh Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER,
Postal Station No. 202.
Telephone, C. & P., Tuxedo, No. 303.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

SPECIAL ALUMNI NOTICE.

The regular meeting of the Alumni Association will be held at the College, April 28, at 7.30 P. M. The Annual Address will be delivered this year by Dr. S. H. Allen, of Utah.

Following this meeting there will be held the customary annual banquet at the Hotel Rennert. An especial effort has been made to have an unusually attractive dinner and all the Alumni are cordially invited to put aside their cares and their work and join with their fellow alumni in trying to make this year's meeting a record one as far as attendance and enthusiasm can go to do it, and that is generally all that is needed. Alumni who will be present are urged to send their names to Dr. Chas. E. Brack, Greenmount Ave. and 20th Street, Baltimore. The price per plate will be \$3.00.

The commencement exercises will be held at Ford's Opera House Tuesday, April 29, at 12.00 o'clock noon. Tickets for this may also be obtained from Dr. Brack. There will be only general admission tickets and no reserved seats.

THE FOURTH DISEASE.

Everyone who has much to do with children must realize how little we really know concerning the eruptions of the skin as manifestations

of constitutional disease. Sydenham cleared up much that was doubtful and those who followed him have elucidated the problem a little farther when they separated rubella or German measles from measles and scarlatina at the beginning of the nineteenth century.

Rubella has been thought by a number of observers to be not one disease but probably two diseases confused. In Ziemsen's Encyclopedia this view is expressed as a possibility, and Filatow, the most famous of the Russian pediatricists, as early as 1885, as well as Jurgensen at a later date, gave voice to the same opinion, without, however, giving us any definite reasons for thinking so. Griffith, of Philadelphia, remarked at a recent meeting that he had long been in the habit of describing two forms of German measles, rubella morbilliforme and scarlatiniforme, although he believes them to be identical.

Certain it is that in some cases of rubella the disease bears a certain resemblance as far as eruption goes to measles, while in others it resembles scarlatina.

Dr. Clement Dukes, the physician to the celebrated Rugby School, has stated in a rather authoritative manner that there is a distinct difference, and he calls the newly separated disease the "Fourth Disease." He bases his opinion on the study of three epidemics which he studied at Rugby. He maintains that the fourth disease has a longer incubation period than scarlatina and about the same length as that of rubella (9-21 days); that there are never any severe symptoms or sequelæ; that there is never the furred white tongue which desquamates on the fourth day, leaving the typical raspberry tongue of scarlatina; that the rash comes out all at once, reaching its full development in a few hours and that desquamation bears no relation to the intensity of the rash. There are other differences from scarlet fever that he gives but these are the most important. From rubella there is especially the rash. Under this name he would place only the cases with a measles-like eruption. Dukes maintains further, that rubella and scarlet fever do not protect from the fourth disease, neither does an attack of fourth disease protect from scarlet fever or rubella.

Dukes paper, published in the Lancet, has attracted much criticism,

and had it come from a less celebrated man would not have excited anything like the same interest. Broadbent, Rutter and Johnstone confirm Dukes' opinions, while many very good authorities take issue with them. Dr. Pleasants, of our own college, has contributed an able article to one of the medical societies in which he holds that Dukes has not satisfactorily proven his statements and refuting some of them in a report on an outbreak of atypical scarlet fever.

The importance of the question is easily understood when one considers how rampant scarlet fever might become if a fourth disease were accepted by the profession without some good pathognomonic sign or symptom for its more certain differentiation. The fourth disease is a light and trifling affection, while scarlet fever is a justly dreaded danger. As the question now stands we must await more positive evidence before we can say positively whether or not the fourth disease is as now set forth a pathologic entity.

J. R.

MEETINGS OF THE COLLEGE MEDICAL SOCIETY.

Meeting of December 5, 1901: Dr. Wm. P. Spratling, Superintendent of the Craig Colony of Epileptics of New York, addressed the Society on the subject of "Epilepsy: its etiology, pathology and treatment." The meeting was very well attended and the subject was discussed at considerable length by Prof. Latimer Preston, Dr. Fort and others.

On the following evening, December 6, Dr. Spratling illustrated the subject: "The public care of epileptics," with lantern slides. A great many views were shown illustrating the methods used in the care of epileptics at the Craig Colony.

Meeting of January 17, 1902: Mr. Viewig presented a case of tinea favosa with a description of the disease, clinical course, pathology, symptomatology and etiology. Dr. Rosenthal in discussing the case brought out several points with regard to the differential diagnosis and the sociological aspect of the disease.

Mr. Preston read a paper on Anteflexion—the varieties, symptoms, sequences and treatment.

Dr. Gardner made some remarks on the causation and symptoms of the condition.

Mr. Quessy exhibited a case of Meningocele and read a paper on this class of malformations.

Mr. Darling read some notes on the differences between mother's and cow's milk.

Meeting of January 30, 1902: Dr. Ruhräh exhibited some specimens illustrating tracheal diphtheria, colitis and pneumonia.

Mr. Cornell gave a description of the papular eruption in typhoid fever with report of a case.

A biographical sketch of John Hunter was read by Mr. Traywick.

Dr. McGlannan on the history of the rise of chemistry in American medical schools.

Meeting of February 13, 1902: Dr. Keirle gave a demonstration of some of the methods used in Pasteur treatment. A brief account of Pasteur's life was given; followed by the treatment of a patient, and the inoculation of a rabbit. Dr. Ruhräh outlined the modus operandi of inoculation of rabbits, care of cords, and treatment of patients undergoing treatment.

THE YEToes CLUB.

The Yetoës Club of the Graduating Class celebrated Washington's birthday by having a banquet at Halstead's Suburban Hotel. The Club is composed for the most part of representative men of the class. It was organized in the early part of the year for the purpose of promoting social intercourse among its members. On this occasion all the members wearing the College colors assembled in the library and from there drove in a bus through the snow and sleet to their banquet hall. After a short musical program dinner was served and Mr. C. Waldkoenig introduced Mr. W. F. Dixon as toastmaster. The toasts responded to were as follows: To the Father of our Country, Mr. Viewig; To the Faculty, Mr. Lynch; To the Class, Mr. Schoeniger; To the Yetoës, Mr. Keenan; Wine, Women and Song, Mr. Reich.

Among the members of the Yetoos are Messrs. Schoeniger, Dixon, Viewig, O'Neil, Waldkoenig, Reich, Messenger, Riedy, Ullman, Johnson, Messerly, Keenan, Quessy, Spyker, Nichols, Conlin, Keenan, Lynch, Nealon, McCabe, Johnson, McDonald, McGrath, Donovan and Hilton.

The faculty gave a reception to the class in the College library on March eleventh. On the same evening preceding the reception Dr. Musser, of the University of Pennsylvania, gave a lecture to the College Medical Society on the "Therapeutic Measures Employed in Pneumonia." Dr. Musser's lecture was greatly enjoyed by the Society and the reception which followed was one of the most successful that the College has ever given. The social features were enhanced by a splendid musical programme rendered under the skillful supervision of Dr. Brack. An excellent supper was served during the evening.

The Phi Beta Pi Fraternity gave their first annual banquet at the Hotel Rennert, February the eighteenth, at the Hotel Rennert. Before the banquet a business meeting was held at the College building, where behind closed doors with the ceremonies which only the elect are cognizant of twenty-six members were admitted to the Fraternity. Dr. Harry Friedenwald acted as toastmaster and the following toasts were drunk: The History of the Phi Beta Pi, by Mr. Darling; Modern Medical Colleges, by Dr. Gardner; The Incoming Active Members, by Dr. Ruhräh; The Faculty and the Student, by Dr. Harrison; The Initiation, by Mr. Hale; Medical Professional Fraternity, by Dr. Sanger.

THE PHI CHI FRATERNITY.

The Phi Chi Fraternity of the College of Physicians and Surgeons was formed January 28, 1902, receiving its charter from Alpha Chapter, University of Vermont on February 1, 1902. The following charter members were "Exalted to Phi Chi" at the Beta Chapter House, 851 Hamilton Terrace, Baltimore, on February 1, 1902: Martin Sullivan, Fritz G. Kirmayer, G. L. Wyatt, W. D. Sudler,

Courtney Allen, J. M. Hoag, J. E. Hayes, F. B. Cornell, H. O. Wilmot, G. O. Brinkley.

The first annual banquet was held at the Academy Hotel Thursday, February 27, 1902. Covers were laid for forty. Prof. H. H. Hayden presided as toastmaster. The following members responded to toasts: The Study of Anatomy, Dr. S. B. Grimes; The Fraternity, J. M. Hoag; "F. G.", Dr. A. Samuels; The Medical Student, Dr. Mitchell; Future of the Phi Chi, Dr. M. Eckstromer; History of the Phi Chi, G. O. Brinkley. Among the other speakers were Messrs. Fitz Kirmayer, Martin Sullivan, G. L. Wyatt, H. O. Wilmot, W. D. Sudler, F. B. Cornell, C. T. Allen, J. O. Hayes, Drs. Brown, Wilcox, and Mather.

The present officers of the Fraternity consist of: President, Stephen Donovan; Vice-President, Martin Sullivan; Secretary, G. O. Brinkley; Treasurer, H. O. Wilmot; Doorkeeper, G. L. Wyatt; Marshall, E. L. Messenger.

The history of the Phi Chi dates back to 1879, A charter being granted to the University of Vermont by the State in that year. At the present time chapters are established at Bowdoin University of Maine, Baltimore Medical College, Dartmouth, Tufts, Cornell, and Columbia University.

WATSON-JONES.

The JOURNAL's congratulations come a little late but none the less heartily to Dr. and Mrs. Watson, of West Hartford, Vt.

Dr. J. William Watson, '00, also a graduate of Dartmouth, and one of the Residents at the Presbyterian Eye and Ear Hospital on East Baltimore Street, was married to Miss Cassina F. Jones, a graduate of Mt. Holyoke College, and for several years a resident of Methuen, Mass., on September 3, 1901. The ceremony was performed by the groom's father, the Rev. Albert Watson, and by the Rev. S. P. Leeds. The maid of honor was Miss Mabel Jones, the sister of the bride, and the best man was Rev. A. P. Watson, the brother of the groom. The wedding was followed by a reception and luncheon.

OBITUARY.

During the past year the following of our Alumni have passed away. We regret that we have not fuller details concerning them. For the list as printed we are indebted to Dr. S. W. Woodyard, '91, of Greeneville, Tenn.

Dr. Remus Robinson, '81.

Dr. Jno. E. Garner, '76, of Union, S. C.

Dr. E. C. Frierson, '80, of Anderson, S. C.

Dr. Wm. W. Alderson, '94, of Alderson, W. Va.

Dr. J. Byron Lyman, '78, of Yuba City, Cal.

Dr. Jno. T. Black, '83, of Duquesne, Pa.

Dr. Jesse A. Hartson, '94, of Ava, N. Y.

Dr. Wm. Watson, '86, of Allegheny, Pa.

Dr. Peter O. Dillard, '93, of Martinsville, Va.

Dr. Harry E. Dawson, '92, of North Scranton, Pa.

Dr. Whitecomb E. Pratt, '85, of Buckingham C. H., Va.

Dr. A. F. Sawson, of Berlin, W. Va.

Dr. J. H. Wolfe, '78, Sylvia, N. C.

Dr. George B. McCorkle, '78, Covington, W. Va.

Dr. J. Roy Annett, '82, Aurora, W. Va.

Robert Tabney Ball, M. D., College of Physicians and Surgeons, Baltimore, 1881, died at his home in Baltimore, February 25.

Dr. Russel B. Freeman, '92, died at St. Anthony's Hospital, Denver, Colorado, on March 12, 1902, of appendicitis. Dr. Freeman settled in Denver in 1895 and was one of the most successful practitioners of medicine in that city. He was on the staff of St. Anthony's Hospital and was most highly thought of by all the members of the community.

Personal Notes.

The editors of the JOURNAL would again like to urge the Alumni of the College to send in any changes in their address and personal notes concerning appointments, marriages, deaths and any information of interest that they may have about themselves or others. The columns of the JOURNAL are the means of keeping in touch with your

old chums and every item which is sent in finds many appreciative readers although the sender may consider it a trifle.

A card catalogue is kept of all the alumni of the College that can be kept track of, and we can only keep it up to date if the boys themselves lend a helping hand.

Every member of the Class of Nineteen Hundred and One is especially requested to send a postal card with his address on it to the editors.

DR. S. WATER WOODYARD, '91, who spent several weeks doing post-graduate work in Baltimore during the fall and early winter, has resumed practice at Greenville, Tenn.

DR. B. W. SHIREY, '95, who has been practicing for the past six years at East Prospect, Pa., is with us again taking some post-graduate work. He will in all probability locate at York, Pa.

DR. HENRY DE WITT SHANKLE, '89, Saluda, N. C., will spend the month of January in Baltimore at post-graduate work. The doctor is Examining Surgeon for the U. S. Pension Board at Hendersonville, N. C.

DR. THOMAS R. MARSHALL, '93, who has been practicing in Richmond, Va., has been appointed assistant surgeon of United States Volunteers with the rank of captain. He has been ordered to the Philippines.

The Hinton Hospital at Hinton, W. Va., has several of our Alumni on the staff. Among the consultants are DR. J. G. HALEY, '89, DR. J. T. HUME, '87, and DR. S. P. PECK, '77. DR. L. O. ROSE, '01, is the Bacteriologist in charge of the clinical laboratory.

DR. E. A. BOWERMAN, '95, who has been, since he left the City Hospital, connected with the Buffalo State Hospital for the Insane, is spending the winter here doing post-graduate work at the College, at the Johns Hopkins Hospital under Professor Osler, and with Dr. Charles Simon in his private laboratory. Dr. Bowerman has one of the best positions in the New York State Service, and is an Alumnus of whom we are all proud.

5 SECONDS BY THE WATCH

OUR HYPODERMATIC TABLETS

DISSOLVE COMPLETELY, IN FIVE SECONDS BY THE WATCH



Immediate action!—that is what the physician expects in a hypodermatic tablet. It is what he should **demand**.

The tablet which meets this requirement—the tablet which can be relied upon in an emergency—must have the merit of **quick and complete solubility**.

It is not sufficient that it fly to pieces when thrown into water.

Many hypodermatic tablets do that, their undissolved particles settling to the bottom. This is mere disintegration—**not solution**.

Ours **dissolve**—dissolve **completely**—in five seconds.

Drop one of them into a syringe half filled with luke-warm water, shake vigorously, and note results.

Try it!

Parke, Davis & Co.'s Hypodermatic Tablets have never failed in an emergency. Prompt, efficient action follows their administration—**always**. There is never any delay, never any uncertainty.

Use them!

HOME OFFICES
& LABORATORIES.
DETROIT, MICH.
BRANCH LABORATORIES
HOUNSLOW, ENG.
WALKERVILLE, ONT.

PARKE, DAVIS & Co.

BRANCHES IN
NEW YORK, KANSAS
CITY, BALTIMORE,
NEW ORLEANS, CHICAGO,
LONDON, ENG.,
& MONTREAL, QUE.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, N. Y., Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S. Ohio.
E. PARMLY BROWN, D. D. S. N. Y.
A. L. NORTHPROP, D. D. S. N. Y.
E. L. HUNTER, D. D. S. N. C.
W. W. WALKER, D. D. S. N. Y.
OSCAR ADELBURG, D. D. S. N. J.
G. MARSHALL SMITH, D. D. S. Md.
C. M. GINGRICH, D. D. S., Resident. Md.
J. HALL MOORE, D. D. S. Va.

R. B. DONALDSON, D. D. S. D. C.
H. A. PARR, D. D. S. N. Y.
J. EMORY SCOTT, D. D. S. Md.
C. L. ALEXANDER, D. D. S. N. C.
M. M. MAINE, D. D. S. Conn.
J. W. DAVID, D. D. S. Texas.
A. C. BREWER, D. D. S. Md.
J. ROACH, D. D. S. Md.

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

W. W. DUNBRACCO, D. D. S. J. K. BURGESS, D. D. S. J. C. SUTHERLAND, D. D. S.
GEO. V. MILHOLLAND, D. D. S. CHAS. THEBERATH, D. D. S.
L. M. PARSONS, D. D. S. HARRY E. KELSEY, D. D. S. C. H. CARSON, D. D. S.
H. M. LEVER, D. D. S. C. S. GORE, D. D. S. L. F. PALMER, D. D. S.
C. R. STEWART, D. D. S. L. D. CORIELL, D. D. S.
H. H. HAYDEN, M. D., Demonstrator of Anatomy.
C. F. BLAKE, M. D., Demonstrator of Anatomy.

The Sixty-Second Annual Session will commence on the 1st of October, 1901, and continue until May, 1902.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.

ANNOUNCEMENT
OF
POST-GRADUATE COURSES
FOR
PRACTITIONERS OF MEDICINE

Beginning April 28th, 1902, and continuing for six weeks. These embrace courses in *Medicine* (including daily visits to the medical wards), *Pediatrics* and *Nervous Diseases*, *Surgery* (general, orthopedic, genito-urinary surgery and cystoscopy), *Gynecology*, *Operative Obstetrics*, *Ophthalmology* (including a course in the use of the Ophthalmoscope), *Otology*, *Laryngology*, *Pathology* (Demonstrations of fresh specimens and microscopic course), *Bacteriology* and *Clinical Laboratory* courses in the microscopic and chemical examination of the blood, urine, gastric juice, feces, etc., etc.

These courses *are entirely* practical.

A certificate of attendance will be given at the end of the course.

For schedule and further information apply to

DR. HARRY FRIEDENWALD, CHAIRMAN,

College of Physicians and Surgeons,

BALTIMORE, MD.

College of Physicians and Surgeons OF BALTIMORE.

—>>> FACULTY <<<—

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- AARON FRIEDENWALD, M. D.,
Professor of Diseases of the Eye and Ear.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Medical Jurisprudence and Director of Pasteur Institute.
- C. HAMPSON JONES, M.B., C.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, M. D.,
Professor of Obstetrics.
- WM. ROYAL STOKES, M. D.,
Professor of Pathology and Bacteriology.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- W. F. SMITH, A. B., M. D.,
Associate Professor of Surgical Anatomy.
- B. HOLLY SMITH, M. D., D. D. S.,
Professor of Principles and Practice of Dental Surgery as applied to Medicine.
- HARRY FRIEDENWALD, A. B., M. D.,
Associate Professor of Diseases of the Eye and Ear.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MOULEARY, M. D.,
Associate Professor of Physiology and Demonstrator of Histology and Pathology.
- CHARLES E. BRACK, M. D.,
Associate Professor of Obstetrics.
- JOHN RUHRAH, M. D.,
Associate Professor of Diseases of Children and Demonstrator of Pathology.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy and Demonstrator of Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Clinical Professor of Diseases of the Rectum.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MOGLANNAN, M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- THOMAS E. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- MELVIN ROSENTHAL, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- ALBERTUS COTTON, M. D.,
Demonstrator of Osteology and Lecturer on Orthopedic Surgery.
- GLENN M. LITSINGER, M. D.,
Demonstrator of Obstetrics.
- M. EKSTROMER, M. D.,
Demonstrator of Chemistry.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- SYLVAN ROSENHEIM, M. D.,
Demonstrator of Bacteriology.
- ARCHIBALD C. HARRISON, M. D.,
Demonstrator of Anatomy.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Clinical Assistant in Gynecology.
- S. S. HOULTON, M. D.,
Demonstrator in Clinical Laboratory and Assistant in Diseases of Stomach.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- OTTO D. SCHAEFER, M. D.,
Assistant in Eye and Ear Diseases.
- JOHN MASON KNOX, JR., M. D.,
Demonstrator of Pathology and Physical Diagnosis.
- CHARLES B. CANBY, M. D.,
Demonstrator of Pathology.
- A. G. FREEDOM, M. D.,
Assistant in Diseases of Stomach.
- C. W. G. ROHRER, M. D.,
Assistant Demonstrator in Pathology.
- OTTO GLASER, A. B.,
Demonstrator of Embryology.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Issued Quarterly

Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS

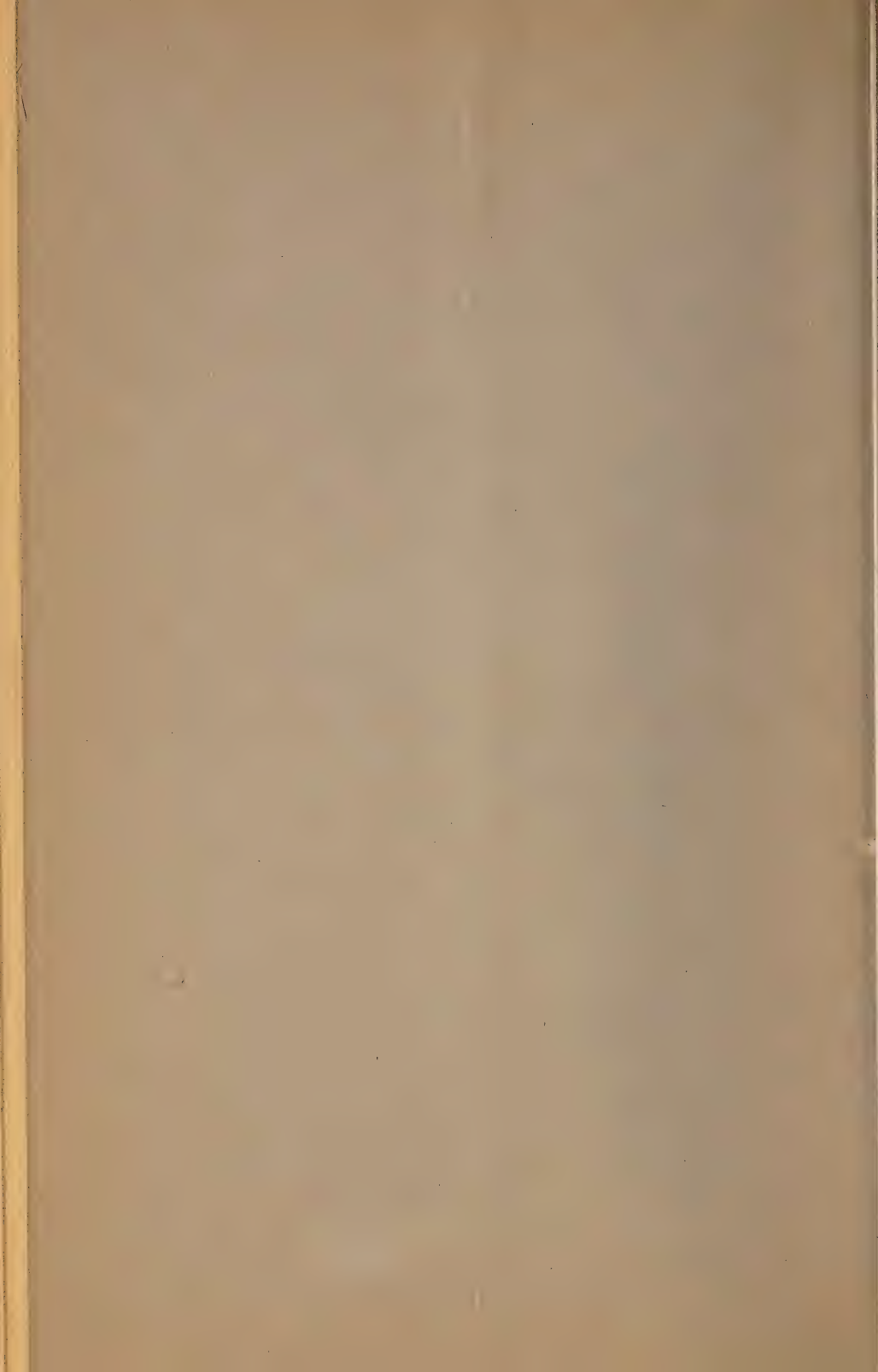
BALTIMORE.

Vol. V

No. 2

JULY, 1902

PUBLISHED AT
Baltimore and Eutaw Sts. Baltimore, Md.



The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME, Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,
CATONSVILLE, MD.

REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
A Brief Review of the Development of Obstetrics. DR. CHARLES EMIL BRACK,	33
General Anesthesia. DR. ARCHIBALD C. HARRISON,	43
Enlarged Prostate. DR. H. M. ORR,	50
A Report of a Case of Chlorosis in the Male. DR. R. L. NEWELL,	54
A Misplaced Kidney. DR. S. BUTLER GRIMES,	56
Editorial,	57
Personal Notes,	iv, 64

"OUR
LEADER."

Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.



All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,
MANUFACTURERS AND IMPORTERS,
300 N. HOWARD STREET, - - - BALTIMORE, MD.

PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES.

ANNOUNCEMENT
OF
POST-GRADUATE COURSES
FOR
PRACTITIONERS OF MEDICINE

Beginning May 1st, 1903, and continuing for six weeks. These embrace courses in *Medicine* (including daily visits to the medical wards), *Pediatrics* and *Nervous Diseases*, *Surgery* (general, orthopedic, genito-urinary surgery and cystoscopy), *Gynecology*, *Operative Obstetrics*, *Ophthalmology* (including a course in the use of the Ophthalmoscope), *Otology*, *Laryngology*, *Pathology* (Demonstrations of fresh specimens and microscopic course), *Bacteriology* and *Clinical Laboratory* courses in the microscopic and chemical examination of the blood, urine, gastric juice, faeces, etc., etc.

These courses *are entirely* practical.

A certificate of attendance will be given at the end of the course.

For schedule and further information apply to

DR. HARRY FRIEDENWALD, CHAIRMAN,

College of Physicians and Surgeons,

BALTIMORE, MD.

Personal Notes.

DR. H. W. B. ROWE, '01, is located at Goldsboro, Md.

DR. WM. VENNER DUNLOP, '97, is practicing at Rush Run, W. Va.

DR. CHARLES H. BANGS is demonstrator of anatomy in the same institution.

DR. B. W. BEST, '84, has left Eureka, N. C., and has settled in Greensboro.

A CARD.

At the beginning of another season, we beg physicians to consider the advisability of sending more of their patients to us for prescriptions and sick-room supplies. We will waive matters of ethics and base our claims for additional patronage upon the excellent character of our work, the better results secured through concentrated efforts and upon the advantages a comprehensive stock gives us.

MICROSCOPICAL AND
CLINICAL SUPPLIES.

HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

S. & D.'S HYPODERMIC TABLETS

were the first porous, and hence quickly soluble hypodermic tablets offered to the medical profession. Their high standard of excellence in solubility, uniformity and reliability has been maintained uninterruptedly since their inception. They have been frequently known as cold water tablets, because they dissolve faster in cold water than most others do in warm water, and it is generally admitted that they

ARE THE MOST SOLUBLE

hypodermic tablets offered the medical profession to-day. No watch is necessary to time their rate of solubility, as is the case with other makes, for they dissolve instantaneously. Merely drop a tablet into the syringe barrel, add some water and one instantaneous shake will be followed by complete solution.

SHARP & DOHME

BALTIMORE.

CHICAGO.

NEW YORK.

NEW ORLEANS.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap has been used exclusively in this baby's bath from birth, and her perfect skin and luxuriant hair excite wonderful interest and admiration.

AS A NUTRIENT SOAP
FOR THE SKIN . . .

Resinol Soap

IS WITHOUT A
. PARALLEL.

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.,
SYDNEY, N. S. W.
Agents for Australasia.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

A BRIEF REVIEW OF THE DEVELOPMENT OF
OBSTETRICS.

BY DR. CHARLES EMIL BRACK, '95.

Obstetrics is the youngest branch of medicine, and dates its existence as an independent branch of medicine from the beginning of the eighteenth century.

In the earlier days of the fathers of medicine up to the seventh century obstetrics was in the hands of women exclusively and physicians and surgeons were called in as consultants only when in extreme need. The operation which these gentlemen indulged in was the destruction of the child to save the mother's life, which latter was frequently not successful.

From the seventh century to the beginning of the eighteenth obstetrics was a branch of surgery, still largely in the hands of midwives, and practiced by surgeons on a mechanical basis of manual assistance and operative interference in cases of extreme need.

From the eighteenth century, beginning with von Deventer, we have a period in which scientific investigation taught the recognition of natural forces, showed clearly the anatomical and physiological basis of pregnancy and labor, gave us the forceps and laid the practical foundation of the obstetrics of to-day.

We can readily understand why obstetrics should have received such tardy recognition and even contempt from the medical men of earlier days.

Medical cases were public property, and a case was often exhibited in the public square to receive advice and treatment from the public.

Labor, however, was conducted in seclusion in the presence of the husband and elder female relatives. Some of these elder female relatives from inclination or other reasons extended their operations beyond the confines of the home to other relatives and friends, and thus the midwife came into existence.

Ancient history contains few references to medical attendants, but mention of the midwife is frequent.

Advice of the medical man was often sought, but the actual presence did not occur. Such condition exists at the present day in Turkey and Asia Minor. Assistance rendered by midwives at this time was of the simplest kind. The woman was placed in position and supported, the child when born was received and traction was usually made upon the part first born. The cord was tied in a knot, occasionally a ligature was put on. The placenta was delivered by traction upon the cord. Head presentations were considered the only natural ones. When abnormal presentations occurred, an attempt was made to change them by rubbing or stroking the abdomen vigorously. As our medical forefathers did not attend normal labor cases, their writings give us but little information; but we can judge of the customs prevalent in earliest days by the observation of primitive people of later times. Let us glance at some of these customs.

The menstruating woman and the woman during the puerperium were considered unclean and were required by custom to remain isolated during these periods; among some people the abode occupied, together with the clothing worn and used during the lying-in period, were burned. Often it was the custom that a woman went alone to the woods near to a running stream, gave birth, washed herself and babe and returned to her household duties.

Among some other tribes, confinement was a public affair, and everybody was present, friends and relatives crowded around; if labor was slow a great noise was made to help things along.

Labor was usually short, lasting from one to four hours. Inter-marriage with members of civilized races usually proved disastrous and difficult labors resulted, owing to larger heads of the children.

Rather peculiar treatment was accorded the pregnant woman during the latter part of pregnancy. Daily inunctions, and rubbing and kneading of the abdomen to facilitate labor were employed. Starving was resorted to, to produce hunger in the child and force it to come out for nourishment.

During labor a position peculiar to the people was adopted. Some knelt, some squatted, some stood upright, or hung suspended by the arms from a convenient tree branch; among others a chair made for the purpose or a convenient stone was used. The position less frequently adopted by primitive people was the recumbent one so prevalent in all civilized countries to-day. The most frequent was the semi-recumbent.

If labor was slow, assistance was given by pressure upon the abdomen, kneading and rubbing; a tight binder was placed over the abdomen and gradually tightened, or the woman was grasped by the feet and shaken. After birth of child, if the placenta was not properly delivered, the abdomen was again subjected to pressure and kneading; traction was made upon cord; or the woman was made to walk about. Sometimes a cloth was used as a tourniquet over the abdomen, or the woman would lean against a pole, pressing the end of it against her abdomen; at times an assistant would stand upon the abdomen with both feet. Emetics and purgatives were at times given to expel the placenta; the woman was made to cough; to blow through her fist. Steaming and fumigations were resorted to. Abortions, perineal tears and prolapse were not infrequent occurrence.

Among the earliest writers who make mention of things obstetrical we must turn to Hippocrates, 460-370 B. C. Among his aphorisms we find some observations regarding menstruation and its irregularities; also regarding the sex of children, always a fruitful topic. Males, he taught, were carried on the right side, females upon the left; flabbiness of breasts was a sign of fetal death. A seven months' child is more apt to live than one at eight months. A male child is formed 30 days after conception, a female, 42 days.

Hippocrates advises to hatch 20 eggs and examine one daily to note its development, and the changes occurring were rather minutely described.

He speaks of faulty presentations, and ascribes them to too great width of uterus. Version upon the head is advised in these cases.

If an extremity is prolapsed and child dead embryotomy is advised, and then follows a description of opening the head, removal of bones, cutting off of extremities and opening chest and abdomen of child. A description is given of curved knives, hooks and other instruments for breaking the cranial bones.

Aristoteles, 384-322, B. C., believed that child sat upright in uterus until eighth month, when it turned a somersault and came down head first. For two thousand years this belief was entertained. After birth of child, the placenta was born by an inversion of the womb.

Celsus, 30 B. C.-14 A. D., advises the introduction of finger in mouth of child to make traction and also mentions manual extraction of after-coming head. He is the first to recommend podalic version. He classified presentations into head, breech, foot and transverse, and recommends bringing down foot in breech presentations.

Earliest book for midwives written by Moschion, A. D. 117. He had knowledge of the membranes, which he calls chorion, and appreciates the value of preserving them, stating that early rupture causes protracted labor. If placenta be not delivered two ligatures should be applied and cord cut between.

Difficult labor, he remarks, is due to feeble development of mother, tumors, hemorrhage and fecal impaction. On part of the child—large head, large body, dropsy and faulty presentation. In breech presentations traction should not be made.

Galen, 200, paid but little attention to obstetrics; his work was chiefly one of research in anatomy and physiology.

Galen lost himself in speculation. He entertained a curious belief that the fetus received its nourishment by mouth, suckling upon cotyledons.

After Galen we reach a period of decadence of medicine and find

but fruitless repetition. Podalic version as recommended by Celsus was not appreciated and found no favor.

About 550 one Aetius of Amida refreshes us with some observations upon the placenta and methods of producing abortion, apparently a procedure very prevalent at that time.

He says if placenta is in vagina it should be removed with the left hand well anointed. If in the uterus, forcible traction upon cord should not be made, but placenta should be gradually separated by hand and removed. If os is contracted, dilate with fingers after injecting oil. Snuff can be given and steam baths used.

If this fails do not worry, for the placenta will putrefy in a few days and come away dissolved in blood.

A peculiar belief was held that the child was born by its own exertions, and that if child died its spontaneous delivery was impossible.

The Arabian school which next came into prominence added little that was new to obstetrical knowledge.

We find in Abulkasem, 1122, mention of an extra-uterine pregnancy, in which the fetal bones were removed through an abscess near the umbilicus.

From this time on until the sixteenth century we find little of interest; superstition, ignorance, a decadence of science mark a period of retrogression rather than of progress.

In 980 we find an interesting note of legal injunction to remove fetus from mother dying during pregnancy to insure baptism of child. The Abbot of St. Gall and the Bishop of Constanz were both reputed to have been brought into the world in this fashion.

At the beginning of the sixteenth century—1513—a text-book for midwives was published by Roesselin at the instigation of Catherine of Brunswick. This was a compilation of the writings of Hippocrates, Galen, Avicenna, Aetius and Savonarola. Roesselin like his early predecessors had no practical experience. Of interest in this work are a number of charts picturing the fetus in utero; of twins sailing about arm in arm in an ocean of amniotic fluid; of one twin holding up another by the feet; and of others in various acrobatic attitudes.

He recommends cephalic version, but appreciates the difficulty of this maneuver, and says that the foot may at times be brought down. He advises strongly the use of an obstetrical chair.

In death of the pregnant woman, the mouth, womb and vagina should be kept open to prevent asphyxia of the child. Roesselin's book is a collection of all that was known at the time and is of historic value only.

Jacob Rueff, 1554, in a book on the subject has an interesting chapter on monstrosities, which he ascribes to intercourse with the devil.

Other works appeared which show a growing interest in anatomical research.

Vessal, 1514, of Brussels, realizes the importance of pelvic structure upon labor, describes the pelvic outlet and the sacral bone.

Realdus Columbo, 1544, describes accurately the position of the fetus in the uterus and recognizes the importance of the amniotic fluid; he discards the old notion that the fetus changed its position at time of labor.

Gabriel Fallopius and Bartholomaeus Eustachius made many original observations as a result of dissection of animals and of post-mortem dissections. The structure and position of the uterus, the round ligament and tubes are well described.

This period marks a growing interest of surgeons in obstetrics and we find surgeons devoting their energies to this branch by preference.

A landmark in history is the work of Ambrose Pare, 1510 to 1590. He is the first after Celsus to advocate podalic version, even in head presentations, if labor must be terminated rapidly.

Destructive operations upon the child should only be performed upon the dead fetus or when the mother is in extreme danger.

Guillemeau, 1594, a pupil of Pare, develops podalic version and mentions as further indications hemorrhage, convulsions and placenta praevia, which latter was looked upon as an accidental prolapse. He speaks of the successful Caesarean section upon the living, but does not approve of the operation.

Rather frequent mention is made of Caesarean section at this period.

Francois Rousset, 1581, published a book upon the subject. The incision abdominal was made not in the median line but laterally.

The uterine incision was not closed and a tube was placed into the cervix as a drain. One woman was delivered six times by Caesarean section, but died in her seventh confinement because the operator had died previously.

Many of the Caesarean sections were no doubt cases of extra-uterine pregnancies and often unnecessary, as many women subsequently had normal labors.

Pelvic contractions and deformities were not realized; obstruction was believed to depend upon contraction of the os uteri and to a lack of separation of the pelvic bones.

Julius Caesar Arautius, 1530-1589, was the first to recognize pelvic deformity and understood the normal pelvic structure.

The first suggestion of symphyseotomy comes from Severinus Pinaeus, who demonstrated motility of innominate bones upon the cadaver of a woman who had been executed for infanticide after childbirth.

Thus observations and investigations from one man and another furnished contributions to the underlying structure of obstetrical science. Most of these contributions, however, were in the field of anatomy and physiology and in the line of surgical and operative manipulations. The midwife still held the most important position. Those surgeons who interested themselves in this branch limited their interest to the operative feature. They cared very little for the normal labor.

With the beginning of the seventeenth century there came a change and the man who is largely responsible for the change is Francois Mauriceau, 1668. His book on obstetrics was translated into the languages of all civilized countries.

His work is based upon a thorough knowledge of anatomy and contains the first description of normal labor. He appreciates the influence of the bony pelvis and systematizes faulty presentations and their treatment.

His observations regarding placenta prævia are accurate, although

he still believes in accidental prolapse. He delivered 12 cases of this complication without one death, but lost eight children.

Presentations of the occiput he considers the only normal and face presentations, he advises, should be converted into occiput.

The indications for podalic version are clearly outlined, but of Caesarean section and symphyseotomy he does not approve. His book also contains mention of the Chamberlen secret and of Chamberlen's fiasco when he endeavored to deliver a rachitic dwarf by means of his secret instrument. After working for three hours Chamberlen failed and the woman died 24 hours later. The autopsy showed extensive lacerations of the vagina and perforation of the uterus.

The work of Paul Portal, a contemporary of Mauriceau, was quite on a par with Mauriceau's, but was overshadowed by the latter's prominence. Portal insisted upon non-interference and taught that both face and breech presentations should be left to nature. He studied and understood the natural forces and showed wonderful advance in obstetrical diagnosis.

Other men of this period who deserve mention are Philipe Peu, 1694, who published observations of 5000 cases in the Hotel Dieu. He paid especial attention to the third stage of labor and cautions the removal of all membranes with the placenta; he describes adherent placenta and hour-glass contractions of uterus. In placenta prævia centralis he perforates placenta and delivers child through the rent.

Jean Ruleau, 1689, after successful Caesarean section, defends this operation against Mauriceau.

De la Motte, 1678, preached patience and time in primipara; he says that slow labor and gradual dilatation give best results.

Like all others of his time, podalic version is considered the means of all others in difficult labors but his book is filled with prayers for an instrument or a means to overcome the difficulties of an impacted head.

(To be continued.)

GENERAL ANESTHESIA.

BY DR. ARCHIBALD C. HARRISON.

The blessings of anesthesia are indeed not unmixed, and beside the inherent dangers which must be present in more or less degree in all cases, there remains a large number in which the question of anesthesia is a far graver one than that of the operative procedure. The subject has received a large share of consideration since its discovery, but more especially in recent years, and few fields have yielded more liberal results to the laborer or greater benefits to mankind. The accumulation of literature upon the subject is enormous, the workers in the field are many, the importance of this branch of medicine and surgery is second to none, and yet how few there be who, from a practical standpoint, can be justly considered competent anesthetizers! It would be unjust, I believe, to lay the whole blame upon the individual, because in most cases it can truly be said that so little and so superficial has been his instruction and so few his opportunities for practical experience that they amount literally to almost nothing. Beside the neglect of the subject in the regular medical course, there be those who fail to appreciate the gravity of general anesthesia and in fact consider the subject all too trivial for serious contemplation, and by their influence largely spread abroad a most pernicious spirit. In this connection let me beg of you not to confound a proper appreciation of the inherent dangers of anesthesia with fear and timidity in its administration. He who mocks at proper care and precautions is not a safe man with whom to entrust your patient, for it is he who must carry him to the verge of death and he should be in position to vouchsafe his complete return to life. He who best appreciates the dangers of all anesthetics and is most considerate of his patients' welfare is the best anesthetist, for indeed eternal vigilance is the price of safe anesthesia.

In the consideration of the modes of producing anesthesia the subject will easily divide itself into two, general or cerebral and local. Let us consider first *general anesthetics*. Of this class we need consider but three. All the others may be cast aside as having been

tried in the balance and found wanting in some particular. With these three, nitrous oxide, ether, and chloroform, either alone or in some combination or sequence, the best results may be produced. In a given case the first consideration is safety; second, expediency. To determine these points many things must be taken into consideration, but chiefly the drug, the mode of administration, the patient and the anesthetist. It is not necessary to go into the details as to how these conclusions have been reached, nor would it even be profitable here, but suffice it to say that the preponderance of evidence is largely in favor of nitrous oxide first, ether second, and chloroform third. I would like, however, to call attention to what seems to me to be a fact, that in the consideration of the relative safety of any given anesthetic, the subject should be approached from a broader standpoint and take into consideration the *remote* as well as the immediate results. Could we but know how often the cause of deaths which occur some time after operation, and are usually attributed to that cause, could be traced directly to the effects of the anesthetic, or at least in which these effects in conjunction with those of operation were the determining features between recovery and death, we should have to remodel our figures, and I feel sure there would be less disparity between them. For the present, however, it must be granted that, as between chloroform and ether, the latter has the advantage in the proportion of about five to one; that is to say, that for the average case in the hands of the average man ether is the safer in about these proportions. The latitude between just enough and too much ether is very broad, while with chloroform it is very narrow; in other words, it is just so much *easier* to kill a man with chloroform than with ether. Hence, I think it is fair to state that, all things else being equal, nitrous oxide is the least dangerous, being practically without mortality. Ether is second with a mortality rate usually reckoned at about one in from sixteen to twenty thousand. Chloroform third with an average mortality of one in from three to five thousand.

In making a choice of anesthetics so many things must be taken into consideration, such as the age, the sex, and temperament of the

patient, the seat of the contemplated operation, the heart and general circulatory apparatus, the kidneys, the respiratory apparatus, the environments, etc., that manifestly it is quite impossible and perhaps even unprofitable to attempt to consider all of them here, and we shall therefore pass them over, in part at least, as well worthy of discussion as they may seem.

As a working basis it may fairly be assumed that there is practically no age and but few conditions which will not permit of some form of general anesthesia when such is demanded and properly administered. Ether is unquestionably most suitable for general use but chloroform has and will probably always have a large number of subjects in which it best fulfills the objects sought to be attained.

Of the three drugs which we have selected as best adapted to the purpose, let us consider first nitrous oxide. Though it was long believed, and still is by some, that this gas was purely negative, producing its effects by the displacement of oxygen, it is now pretty well established that it is a true anesthetic. By the proper admixture of oxygen or atmospheric air the anesthetic state may be maintained for fairly long periods, and operations of considerable gravity may be completed under its influence. Its chief use is still found in dentistry, minor surgery and as an adjunct to ether and chloroform, preferably the former—in any event, it requires special apparatus and considerable experience to exhibit it to the best advantage. In general surgery it is principally used in sequence with ether. To apply it properly we must have an apparatus by means of which the supply of gas, ether vapor and air or oxygen can be definitely controlled, such as Bennett's, Goldau's, Clover's and others.

The method is to first anesthetize the patient with gas, gradually turning on ether vapor until the patient is firmly under its influence, and then the ordinary ether cone may be substituted or not at the discretion of the anesthetist. Manifestly, as the supply of air is much diminished and cyanosis a common accompaniment, chloroform is less desirable than ether. The advantages are that the patient goes to sleep in a very safe and agreeable manner instead of a very trying one; the length of time required is reduced to a minimum;

the quantity of ether required is greatly curtailed and the deleterious after-effects are lessened in proportion. This probably constitutes as nearly an ideal method for general use as can be procured, when properly administered. For the administration of ether alone three methods may be considered—the open, the semi-open and the closed. The first may be discarded as impracticable. Of the last that it requires special instruments and is safe in the hands of the expert only. Leaving the semi-open, which I think is the safest, best and most agreeable method. No special apparatus is required, though Allis' inhaler serves very well. A well-made cone composed of paste-board and covered with a towel, into the apex of which is stuffed a moderate quantity of absorbent cotton, is probably as good as any. There is some advantage in having the cone open at the top sufficiently to admit the ether to be added without removing it. In the administration by all means proceed slowly. The patient should at all times have a reasonable admixture of air, but in the beginning it should be most abundant—the cause of struggling is usually first excited by the vapor being too concentrated, causing closure of the glottis. This action is not the result of a vicious humor of the patient, as we are apt to think, but one over which he has no control and indicates that the cone should be removed until one or two full respirations can be had. Later, however, in the stage of excitement when struggling occurs, in spite of the fact that respiration is free, more ether should be given. After the patient is once anesthetized to the surgical degree, strive to keep him so with the least amount possible. No more difficult point presents itself than that of determining at all times when the patient has just enough. A close study of the corneal, pupillary and pharyngeal reflexes will enable you to come as near this point as possible. Efforts at swallowing, vomiting and oscillation of the eyeballs are perhaps the first and most important indications that the anesthesia is becoming too light. The pupillary condition is of the utmost importance, but its meaning is more difficult to translate because its dilatation may be either reflex or paralytic. A distinction may usually be made by noting the absence or association of other reflexes. A dilated pupil which does

not react to light and is not associated with other reflexes is always a sign of grave danger.

Chloroform.—In its administration quantity is the all-important point. Reduce it to the smallest possible amount consistent with complete anesthesia, and let this be breathed with the freest possible admixture of air. To accomplish these ends always use an Esmarch or Skinner's mask, and give it drop by drop. Bear in mind that when accidents occur from chloroform it is nearly always in the early part of administration. After a struggle, or as the patient is falling into true anesthesia, the respirations usually become very full and deep, hence it is easy to give an overdose at this stage. It is just here that accidents usually occur. The lesson is clear: do not push the anesthetic now, but rather withdraw it and let the patient get two or three full breaths of fresh air. In this manner the danger of overdosing is greatly lessened.

It has been said and most truly, I believe, that when death occurs from chloroform it is nearly always due to unskilful administration and that unskilful administration means overdosing. In other words, though chloroform must have an inevitable mortality, the danger lies more in the anesthetist than the drug. At a given temperature the density of chloroform is far greater than that of ether and a correspondingly larger quantity may be inhaled at a given time; per contra, once having reached the blood it leaves it far more slowly. These physical properties furnish a ready explanation for the fact that chloroform is safer in tropical climates. Lowry, of India, reports forty-five thousand administrations without a death. If it were always properly administered with full knowledge of its physical and physiological properties, its comparison with ether would be far more favorable.

As to the various mixtures, the now famous A. C. E. combination is probably the most deserving. It consists of alcohol one, chloroform two, and ether three parts, respectively. It is probably no safer than ether alone for general use, but has some advantages in certain cases. The plethoric, obese, weak hearts, alcoholics and those who have been etherized several times and now fail to respond properly to ether alone.

The chloroform-ether sequence is valuable in many cases where the air passages strenuously resent the irritation of ether vapor. Chloroform may be used to blunt the sensibilities, then followed by ether, or again where the depression of prolonged chloroformization is feared, it is well substituted by ether. In this connection it must not be forgotten that most accidents from chloroform occur in the early stages.

The A. C. E.-ether sequence is said to be specially suitable for children and weaklings. The ether-chloroform sequence is not infrequently desirable, finding its best application in cases where the primary depression of chloroform is feared and prolonged saturation with ether prohibited.

We have said that by far the most important single point in the administration of an anesthetic is the quantity of the drug, but second to this one alone is that of providing at all times a free and unobstructed route to the lungs. This is best accomplished by keeping the head slightly extended, the lower jaw well forward so that the lower teeth protrude beyond the upper, and the pharynx free from mucus and foreign bodies. When these maneuvers are properly executed it will rarely, but may occasionally, be necessary to pull the tongue forward with forceps.

By far the most valuable evidence we have for estimating the patient's condition is gained by keeping constantly under observation the color, quality of pulse and respiration and the pupillary status. A trustworthy anesthetist will never for a single moment lose sight of some one or all of these four points.

What can be done for the patient who has had too much anesthetic? A great number of things have been recommended, but the value of most of them is purely imaginary. It is here, if anywhere, that an ounce of prevention is worth pounds of cure. So we say first, don't give him too much. But, if because of some idiosyncrasy and in spite of your constant vigilance, it should occur, be in position to stop it at the first indication. With ether there is usually plenty of time for consideration, but with chloroform danger arises almost instantly and you must be in position to act with equal celer-

ity, if you are to accomplish the most good. Place the patient in the dorsal position, head down and moderately extended; provide him with an abundance of fresh air and *see that he gets it*. To accomplish this, hold the tongue well out of the mouth and make alternate traction and relaxation at the rate of sixteen to the minute. At the same time artificial respiration should be actively practiced by a second individual, and Sylvester's method is best. If you are to succeed you must begin promptly and life should not be despaired of until these methods have been faithfully practiced for one or more hours. Bear in mind always that artificial respiration is valueless if the glottis is obstructed; therefore investigate this region with a finger for vomited matter and foreign bodies of all sorts.

Of the drugs, strychnine, nitroglycerin, digitalis and ammonia are useful. Strychnine is by far the most valuable, and it is well given as a precautionary measure. The body should be well wrapped and dry heat applied. In shock and great loss of blood infusion of normal salt solution, one to four pints, is of great value.

In regard to the distressing and sometimes dangerous post-anesthetic vomiting, it is well known that drugs are valueless either to cure or prevent this condition. Gastric lavage is perhaps the best treatment and sometimes acts extremely well. R. J. Hess has concluded from his experiments and observation that the vomiting is produced by the absorbed ether being excreted by the glands and mucosa of the stomach and thus causing an acute gastritis; hence the treatment should consist in limiting the amount of the anesthetic to the minimum and furnishing abundant fluid to promote the dilution and elimination of the drug.

He therefore uses the nitrous oxide-ether sequence to gain the first point and for the second gives a large drink of water just before giving the anesthetic, and allows water ad libitum as soon as consciousness returns. He claims that since adopting this plan he has had but little trouble with this condition.

His conclusions seem to me very logical and most worthy of consideration.

ENLARGED PROSTATE.

BY DR. H. M. ORR, '95.

I know of no diseased condition more trying to a patient, or more tedious to the attending surgeon, than chronic inflammation of the prostate of old men. These cases, coming on as they do insidiously, are always neglected, and when the patient consults you, it is either when he finds he has retention of urine, or hematuria. On examination with sound, or catheter, you will find very often that you can get neither to enter the bladder, as they come in contact with the enlarged prostate which occludes the prostatic urethra.

On making a bimanual examination through rectum, you will find a large hard mass at the neck of the bladder, varying in size from an English walnut to a large orange. Very often the patient has not been able to micturate, owing to the position of the mass. There has been for some time a greater or less quantity of residual urine retained; this will feel to the examining finger as a soft baggy swelling, above and behind the tumor felt on pressure bimanually. A few drops of urine may dribble from the meatus, showing that the bladder is not capable of emptying itself, owing to the mechanical obstruction caused by the enlarged prostate. It has been the privilege of the writer in the last few years to treat several of this variety of cases.

Father B——, 78 years old, very fleshy, good family history. Called me to see him in September, 1897; on reaching him, on examination, I found an immensely distended bladder, the fundus reached 3 inches above the umbilicus; it was so large that you could see it through the fat-walls of his abdomen. I gave him an anterior urethral injection of a warm I——4000 solution permanganate of potash. After making the parts aseptic, I attempted to pass a large Mercier catheter, when it came in contact with the large prostate. I could not get it to pass the obstruction. I tried other varieties of catheter all of which failed to penetrate the bladder.

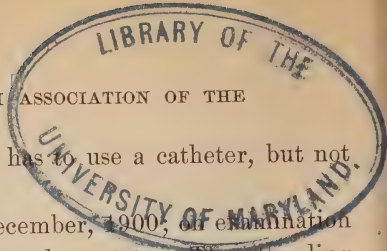
He told me that he had not passed any urine for 72 hours. The danger of rupture of the bladder was so apparent that I advised an immediate operation; he consented, and about 1 hour afterwards the parts were prepared for a suprapubic cystotomy, and the incision was made in the median line about three inches in length, cutting right

down through overlying structures out through the bladder. The incision was followed by a gush of bloody fluid that reached almost to the ceiling of the room. The knife was followed with the index finger of the left hand, the bladder wall grasped with the finger inserted, and then the bladder had nearly emptied; anchor sutures were inserted, the bladder wall was then drawn up, and anchored to the integument.

On exploring the bladder with the finger, I found a mass about the size of a large orange at the urethral opening. I made an incision through the capsule of the mass, and dissected out most of it with my finger nail. The bladder was flushed out with a normal salt solution, and a catheter inserted, which would pass into the bladder on the removal of this obstruction, and a large rubber drainage tube inserted into the wound. For 4 or 5 days after the operation, the patient was delirious; on the 5th day his mind cleared up; on the 10th day I inserted a Senn metal drainage tube; this was left in for 5 weeks and removed, the wound permitted to heal by granulation.

From the time of the operation up to the 5th week, the bladder was irrigated with a I—4000 solution potassium permanganate. He made a complete recovery, regained control of the parts, and lived in ease until 1900, when he died from a stroke of apoplexy.

David R—, 82 years old, occupation farmer, family history negative, was seen by me in consultation with Dr. Hulbert, in September, 1900. On examination we found a distended bladder and a prostate enlargement about the size of a small orange. His physical condition was such that an operation was not advisable. We gave him a hypodermic injection of a $\frac{1}{2}$ grain of morphine, and a 50th of a grain of atropine; in 20 minutes afterwards we managed to pass a medium size Mercier catheter, and drew off 6 pints of bloody urine; we left the catheter in place, irrigated the bladder with a I—4000 permanganate solution, and gave him 10 grain doses of urotropin every 6 hours in a glass of warm milk; this was continued by the attending physician for 4 weeks, and at that time the patient was comfortable, and able to be around; since then he has enjoyed good health and occasionally, when he has any discomfort, a few 10 grain doses of uro-



tropin will relieve him; sometimes he has to use a catheter, but not always.

Adam M—— was seen by me in December, 1900, on examination I found a distended bladder, and enlarged prostate. The attending physician had used a metal catheter with some force, rupturing the urethra, causing considerable hemorrhage; with a good deal of difficulty, and a greater amount of patience, I managed to insert a large Mercier catheter, and removed about 2 quarts of bloody urine. The irrigations were used as in the preceding case with 10 grain doses of uretropin. He made a good recovery, with the exception of the enlargement, necessitating the daily use of the catheter.

Simon B——, 74 years old, occupation farmer, was brought to St. Mary's Hospital, June, 1901, by Dr. James H. Geen, of Utica. On examination I found prostate enlarged as in the preceding cases, and bladder distended to the level of the umbilicus; several attempts were made to pass a Mercier catheter, all of which failed. We scrubbed, shaved and made the abdomen aseptic as possible, then inserted a medium sized vacuum needle; we drew off about 8 pints of bloody urine. This operation was done with a 2 per cent cocain solution. The patient was then given cathartic, high rectal injection and placed in bed, with orders left with the nurse in attendance to give him 10 grain doses of uretropin every 6 hours. The bowels moved profusely during the night; when I saw him the next morning his bladder was distended to almost as great an extent as the evening previous.

I advised a suprapubic operation, to which the patient and family consented. The patient was prepared; chloroform was given as anesthetic; an incision was made two inches in length in the median line down through the overlying structures and into the bladder; this was followed by a gush of bloody urine. On exploring the bladder I found the prostate enlarged to about the size of an orange; the middle lobe was larger than the right or left, and the enlargement of the middle lobe was such that it acted like a ball and socket valve; this was dissected and torn away with a pair of Rongeur forceps; a sound was then passed through the prostatic urethra to the perineal body, where the point of sound could be felt plainly; the median

lithotomy incision was made into the bladder, and a large rubber tube was inserted for drainage. The upper wound was partially closed with silk worm gut sutures and a large rubber tube inserted and anchored with a few stitches to the integument. The bladder was irrigated with a I—4000 permanganate solution daily; the tube in the upper incision was removed at the end of the second week, and the wound permitted to heal by granulation; the lower tube was removed at the end of the third week, and the wound permitted to heal by granulation. After this a medium sized sound was passed daily, until the lower wound was healed, and at this time the patient was able to pass his urine himself.

The patient was discharged at the end of the 9th week, and since then has been in perfect health, doing a great amount of farm work for a man of his years, and was seen by me a few days ago. He told me, with the exception of a little burning occasionally when he urinated, that he had no trouble whatever, and that he did not need to use a catheter.

In making a double operation in this case, I did so for the purpose of having thorough drainage. The preceding operation done on Father B—— was followed by considerable hemorrhage which organized into clots and prevented drainage. The lower operation done on Simon B—— gave perfect drainage, and was not followed by organization of heavy clots, as in the preceding case, making it more satisfactory and getting more benefit from the irrigating which followed. In this class of cases it is my opinion that both the upper and lower incision should be made, for the reason that you get perfect drainage from below and will have a thorough knowledge of the condition of the affairs by inspection and digital examination through the upper wound. The operation devised and practiced by the surgeon of the past and present has not been satisfactory.

The operation of dissecting and tearing away this enlarged mass is followed with a high mortality, owing to the shock following, patients being old men. The operation of the electric cautery, devised by Bertinni, unless in hands of an expert, is dangerous, for the reason that you cannot get an accurate condition of the affairs, and the operation may do serious injury to some of the surrounding structures,

owing to the inability to know the exact position of your knife. One of the best operations that it has been the writer's pleasure to see was that done by Chetwood, of New York, who makes a perineal incision large enough to insert his finger into the bladder and get to the mass and get the accurate condition of the parts; the finger is followed by the electric knife and an incision is made in the lobes that are enlarged. The time occupied in this operation is only a few moments.

The accuracy and rapidity with which the operation can be done, and consequently the lessened shock and the short duration of the anesthesia make it the best operation that has been devised up to the present time.

109 Marquette St., La Salle, Ill.

A REPORT OF A CASE OF CHLOROSIS IN THE MALE.

BY DR. R. I. NEWELL, '02.

The extreme rarity with which chlorosis is observed in the male has led some authors to look upon its existence in a very sceptical manner. The fact that it does exist has been undoubtedly proven. Virchow has observed it in the male. Hayem reports an instance in which all the boys of a family were subject to the disease. Alfred Stengel of Philadelphia mentions a case of undoubted chlorosis in the male. Foster, of the Dresden Children's Hospital, also speaks of it, saying that it is more common in male than in female children under two years. Monti, Sir Andrew Clark and Bramwell also admit the possibility of the condition in the male. After the observation of such careful men as have been cited, there can be little room to doubt the possibility of the disease existing in the male.

The case in question was admitted to the medical ward of the Baltimore City Hospital, October 7, 1901. It was admitted as a suspected heart case, but in routine examination of the blood the chlorotic anemia was suspected. The patient was 14 years old, a Russian by birth, a brunette, well nourished and plump.

The family history was entirely negative, father, mother and two sisters living and in good health.

Past history is that of measles, occurring six years prior to present sickness.

Present condition was first noted three weeks before his entrance to the hospital, when he had severe pains in the left side, stitching in character. This was associated with headache, dizziness, which was especially marked when the patient assumed a stooping position, and shortness of breath on exertion.

The patient on general examination presented a somewhat effeminate aspect. The skin showed a marked yellowish pallor and the mucous membranes were also pale. The feet were slightly edematous but not sufficient to create any discomfort.

The lungs were normal. The spleen and liver were not enlarged, nor could any general glandular enlargement be made out. On percussing the heart, the left ventricle was found extending down and one cm. outside the nipple line; the right auricle extending to the right of the sternum one cm. On auscultation a systolic murmur could be made out over both pulmonary and mitral area. There was no degree of transmission. Pulse readily excited but of good tension. A humming murmur could be heard and felt over the right jugular vein.

The patient was placed in bed and medicine given to relieve the constipation which was present in a persistent form.

Urine had a specific gravity of 10.12, albumen, sugar and diazo all negative.

The blood examination, in the fresh specimen, showed poikilocytes and microcytes. Nucleated reds were not found. The count of the red corpuscles was 3,500,000 per cmm. The hemoglobin was 55 per cent. The leucocytes numbered 5600 per cmm. with 20 per cent of small mononuclear, 4 per cent of large mononuclear, 75 per cent neutrophils, 1 per cent eosinophiles. The patient was given iron in the form of Bland's pills, nutritious diet and rest.

On October 11, the heart dullness was occupying its normal position, the murmurs having disappeared, there remained only a slightly accentuated pulmonic second sound heard over the pulmonic area. The examination of the stool showed no presence of intestinal parasites. The hemaglobin was 57 per cent.

October 18, the patient was feeling a great deal stronger, bowels were regular, the edema had entirely disappeared and the heart was normal. The hemaglobin showed 58 per cent.

October 22, the urine was normal. The blood showed 62 per cent of hemaglobin.

On October 25, the blood gave a count of 3,800,000 red corpuscles per cmm. and 5410 leucocytes per cmm.; 62 per cent of hemaglobin was present.

On November 4, hemaglobin had reached 69 per cent. The patient was then allowed to go home.

A MISPLACED KIDNEY.

BY DR. S. BUTLER GRIMES.

Last winter in the dissecting room upon opening the abdomen of a male cadaver for demonstrative purposes a most unusual position of the right kidney was discovered.

Subject, male; colored; age about 33.

The liver, stomach, spleen, pancreas and left kidney were in their normal positions. The right kidney was discovered in the right iliac fossa lying upon the iliacus and psoas muscles and protruding over the brim into the true pelvis. It was abnormal in shape and size. Its pelvis was very much dilated and the ureter running from it measured only two and one-half inches in length. The right suprarenal capsule was in its normal position in contact with the under surface of the right lobe of liver. Lying upon it was the caecum with its appendix and the beginning of the ascending colon. Running to it, instead of one large renal artery, there were two medium sized arteries which were given off (within one inch of each other) from the aorta two and one-half inches above its bifurcation. The uppermost artery entered the pelvis of the kidney by passing behind it; the lower one by passing in front.

Two veins of unequal size left it; the large one passed up over its anterior and superior surfaces, making a constriction about the size of an English walnut. The smaller vein emptied into the left common iliac vein. From the fact that this kidney was firmly fixed in its position and the point at which its arteries left the aorta, I think we are justified in concluding that it was a congenitally misplaced kidney.

WILLIAM S. GARDNER, M. D., EDITOR,
1012 McCulloh Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER.
Mt. Washington.
Telephone, C. & P., Tuxedo, 984.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

THE POST-GRADUATE COURSE.

As members of the Alumni Association we all feel a great interest in whatever concerns our Alma Mater. Each step forward in the work of medical education is a matter of congratulation to us and every new venture is watched with careful attention.

The latest undertaking has been not on the part of the Faculty, but by the Adjunct Faculty. This energetic, if subsidiary, body, after some little consideration and palaver accepted the idea which had been evolved from the inner consciousness of one or two of its most imaginative members and as a result the Post-Graduate Course was born into existence.

The measure of success that has been achieved has been a matter of surprise. During the first few days even the most optimistic of us was ready to predict failure, but students began to come in and the classes were organized and the work carried out for the most part as scheduled.

It has not only been a success from a practical standpoint, but as far as it is possible for a very prejudiced observer to say it has been satisfactory to those who have been attending the courses. Teaching undergraduates with no knowledge of medicine is one thing, and teaching medicine to men with various degrees of medical knowledge, not only derived from books but from actual experience, is another.

And if we can satisfy the needs of the men the first year that we try a new work, we feel satisfied that we can do it in the future. So it is we declare that the course has come to stay and that it has passed through the experimental stage and is preparing for a system of expansion.

The first year had some faults and we are ready to confess them, because knowing them they can be corrected. Only one need be mentioned. It was thought that some of the men would want to devote most of their time to surgery and some to medicine, and the courses were arranged to allow only one or the other to be taken, as the hours were the same. Most of the students, however, wished to take as much of both as they could and found that they could not follow two masters. The natural result followed. When the surgeons were removing kidneys and gall bladders, doing intestinal anastomoses and abdominal hysterectomies, trifling operations which the average practitioner usually does in his back office and so very necessary for him to know about, the medical man had a very small class. Such hyper-refinements of medical education as the recent progress in infant feeding and the treatment of summer diarrhoea, and the consideration of such anomalous and unusual and therefore not very necessary subjects as the diagnosis and treatment of heart lesions, or of the management of nephritis with the customary bedside demonstrations, found but small interest to the seekers after practical knowledge. We could always tell when the surgeons had good, big operations and when they were doing minor surgery by the size of the medical classes.

But all in all we enjoyed it and we profited by it, both student and teacher. And we want to thank the students for their encouragement and friendliness and extend to all the JOURNAL's congratulations and best wishes.

J. R.

THE ALUMNI ASSOCIATION MEETING.

The Annual Meeting of the Alumni Association was called to order in the Anatomical Lecture Hall at the College by Dr. Todd for the retiring President, Dr. Smith, who was unavoidably absent,

on the evening of April 28. The reading and approval of the minutes, the election of the class of 1902 as members and the reading of the report of Treasurer Brack were gone through with hurriedly, and then Dr. Todd introduced the orator of the evening, Dr. Samuel H. Allen, of Utah. Dr. Allen's address was one which was enjoyed by all and he gave the new members much useful advice in a most entertaining manner.

After a vote of thanks to Dr. Allen, the Chairman of the Executive Committee, Dr. Harry Friedenwald made his report. Dr. Todd reported for the JOURNAL Committee and presented to the College Library a bound copy of the last volume of the JOURNAL.

The following officers were elected to serve for the ensuing year:

President—Dr. Samuel H. Allen, of Utah.

First Vice-President—Dr. Charles F. Blake, of Baltimore.

Second Vice-President—Dr. Thomas A. Cuncell, of Easton, Md.

Secretary.—Dr. Hubert C. Knapp, of Baltimore.

Assistant Secretary—Dr. C. W. G. Rohrer, of Baltimore.

Treasurer—Dr. Charles E. Brack, of Baltimore.

Dr. Allen appointed the following gentlemen to serve on the Executive Committee: Dr. Harvey G. Beck, Chairman; Dr. Melvin Rosenthal, Dr. Frank Dyer Sanger.

The meeting then adjourned to the Hotel Rennert to attend the banquet.

The Faculty, the Adjunct Faculty and the graduating class were for the most part present and besides the guest of honor, Senator Olin Bryan, were a number of out-of-town members of the Association. Among them were: Dr. Thomas A. Cuncell, '94, Easton, Md.; Dr. George W. Boyd, Washington, D. C.; Dr. George N. Yagle, '95, Red Lion, Pa.; Dr. S. M. Stickley, '79, Stephens City, Va.; Dr. E. W. Brown, '87, Washington, Va.; Dr. J. M. Johnson, '96, Coalport, Pa.; Dr. W. D. Row, '83, Parkersburg, W. Va.; Dr. J. J. McCarthy, '96, New York City; Dr. T. H. Brayshaw, '85, Glen Burnie, Md.; Dr. James H. Finch, '95, Champaign, Ill.; Dr. F. W. Hill, '94, Montana, W. Va.; Dr. H. B. McDonnell, '88, College Park, Md.; Dr. S. H. Allen, '90, Provo, Utah; Dr. Charles

H. Bruckner, '01, Newark, N. J.; and Dr. B. W. Shirey, '94, York, Pa.

THE ANNUAL BANQUET.

By far the most successful and brilliant social gathering that the Alumni Association has enjoyed for a number of years was the banquet held this year at the Hotel Rennert. Covers were laid for one hundred guests in the large dining room. The following menu was served:

Little Neck Clams.	Sauterne.	
Celery.	Olives.	Radishes.
	Cream of Celery.	
	Soft Shell Crabs—Cream Gravy.	
	Broiled Spring Chicken.	
Julienne Potatoes.	String Beans.	Medoc.
	Sliced Ham.	Champagne.
	Lettuce—French Dressing.	
Harlequin Blocks.	Assorted Cake.	
Roquefort.	Toasted Crackers.	
	Coffee.	Cigars.

The Toast Master was Dr. Standish McCleary and he was in his happiest vein of humor. The following is the list of the toasts responded to:

- The Medical Profession—Dr. Abraham Arnold.
- The Doctor and the Public—Dr. James Bosley.
- The Doctor and the Law—Senator Olin Bryan.
- The Faculty—Dr. George J. Preston.
- The Medical Student—Dr. W. F. Dixon.
- The Alumni Association—Dr. Wm. J. Todd.
- The Adjunct Faculty—Dr. John Ruhräh.
- The Graduating Class—Dr. W. F. Hale.
- The Post-Graduate Course—Dr. Frank Dyer Sanger.

A HYBRID FEVER.

Edgar J. Spratling, '91, describes a new continued fever, occurring in Forsyth, Georgia. The trouble begins with malaise for three or four days. The general symptoms resemble dengue, and in a few cases may be confounded with grip. The cases were of varying

severity and the temperature reached 106.5° , in many not 100° . In dengue the surroundings have but little influence; in this they were nearly all-powerful. In dengue whole families are usually affected; in this rarely more than one member. He also found that the temperature was susceptible to the action of antipyretics. The symptoms lasted from two to five days, then gave way rapidly, all discomfort disappearing; the appetite returned, the pulse fell to from 85 to 100, the respiration to 30 or 40, and the patients expressed themselves as feeling well, but weak. But the erratic fever and the scanty urine persisted for from three to ten days longer and there were frequently profuse sweats. He believes that this is a close congener of, if not actually, Malta fever.

OBITUARY.

THE HEROIC DEATH OF DR. J. A. BAIRD, '78.

Having the moment before saved the lives of two women, Dr. J. A. Baird, of Dunlo, met a heroic but awful death beneath two steel hopper cars on the Pennsylvania Railroad siding leading to the Henrietta mine of the Logan Coal Company at Landfair, half a mile from his home.

Dr. Baird was on his way to call on a patient. He had ridden from Dunlo to a point near Landfair on a caboose drawn by an engine and when he stepped from the caboose, which stood on the main track of the Dunlo branch of the Pennsylvania Railroad, he started across a siding. Before he reached the siding he saw two steel cars, empty, coming down a grade toward him at a rapid rate of speed. Two women were on the siding and in the path of the approaching cars, which they seemed not to see. They had been shopping at the Henrietta store, just across the tracks, and were on their way home.

The doctor recognized the danger of the women's position and rushed to them, pushing them from the track. On the other side there was a high snow bank and the physician crowded the women

against this. Then he looked for a place of safety for himself. The cars were rapidly bearing down upon him. He stepped back on the track in front of them to cross to the other side and safety. The brakeman on the cars shouted at him. Dr. Baird realized that he could not get out of the way of the approaching machines of death. He faced them and threw out his hands in a futile attempt to save himself. He tried to take hold of the bumpers of the forward car, slipped and was thrown under the immense mass of cold steel.

The death of Dr. Baird was a great shock to the citizens of Dunlo, where he was universally liked. He was 52 years old and had been practicing at Dunlo for the last nine years, having gone there from Jeanette. He formerly lived at Brisbin, Clearfield County. At Dunlo he also conducted a drug store. He leaves his wife, who was a Miss Longenecker, a daughter of John Longenecker, of Woodbury, Bedford County, and a cousin of ex-Judge Jacob H. Longenecker, of Bedford; a daughter, Miss Margaret, aged 14 years, and a son, C. O. Baird, of Roaring Spring.

DR. CHARLES ERNEST GREEN, '91, died of tuberculosis at South Ryegate, Vt., May 26, 1902. Dr. Green was resident physician at the Maternité for one year after his graduation. He then practiced for a time in New York City. For several years he was one of the most successful representatives of the Chas. H. Phillips Chemical Company. He was married in 1892 to Miss Mary Holmes, of Vermont.

Mrs. Alexius McGlannan, the wife of Dr. Alexius McGlannan, '95, of 313 North Greene Street, of this city, died April 30. She was buried at Bonnie Brae Cemetery, the funeral services having previously been held at the Cathedral, where a requiem mass was celebrated. The pall-bearers were the ushers when she was married a few years ago.

DR. DAVID J. UNDERWOOD, '87, died at New Martinsville, W. Va., March 26. Dr. Underwood began the practice of his profession immediately after his graduation and was a most successful practitioner.

DR. GEORGE L. BROWN, '87, of Reedsville, W. Va., died the early part of this year.

DR. JOHN AHL, '75, died at York, Pa., April 4, aged 79.

MARRIAGE NOTICES.

Dr. Charles Hampson Jones, Professor of Hygiene and Public Health, was married to Miss Emma Maie White, the niece of Dr. John S. Fulton, of the State Board of Health, on the evening of June twenty-sixth.

The ceremony was performed by Drs. Smith and Payne at the Church of St. Michael and All Angels. Dr. Frank Dyer Sanger was best man. After the ceremony the wedding party was entertained at supper by Dr. and Mrs. John S. Fulton, at their home on St. Paul Street. Dr. and Mrs. Jones left on the evening train for a bridal tour north and since their return they have taken up their residence at 2201 Bolton Avenue.

DR. R. M. RAU, '93, of Wheeling, W. Va., was married to Miss Sarah Tetrick, of Minington, W. Va., on the 29th of January. Dr. and Mrs. Rau were flying visitors at the College on their wedding journey, which was spent for the most part in Washington and New York. They will settle down in Wheeling where Dr. RAU is one of the most prominent members of his profession.

The subtle charm of propinquity has again demonstrated its power and added another chapter to that continued romance "the Hospital Physician and the Trained Nurse" in that Dr. Albert F. Conrey, '01, formerly one of the internes at the City Hospital, was married to Miss Katherine Bradford, who was one of the trained nurses at the same institution.

Dr. Edward W. Steves, '98, of New Brunswick was married to Miss May Crudden, of Baltimore, on June twenty-sixth.

Dr. Lonzo O. Rose, '01, of Hinton, W. Va., was married to Miss Catherine E. Winstersfeld, of Walnut Hills, Cincinnati, Ohio, on June seventeenth.

Personal Notes.

DR. E. F. MARTIN, '93, formerly of Aurora, has removed to Keyser, W. Va.

DR. HENRY W. DEW, '86, is one of the proprietors of the Lynchburg Sanitarium.

DR. ALBERT WESLEY KAHLE, '83, has removed to 190 Delaware Avenue, Buffalo, N. Y.

DR. EDWARD MCKAY, '01, is now assistant to Dr. WILLIAMS, '80, at Anita, Jefferson Co., Pa.

DR. EUGENE E. WEBSTER, '82, formerly of Hornellsville, N. Y., has moved to Woodhull in the same State.

DR. W. H. BLANKENSHIP, '93, has moved from Annover, Ark., to Altheimer, Jefferson Co., of the same State.

DR. O. T. SPROULL, '86, is practicing at West Union, Ohio, and is secretary of the Adams County Medical Society.

DR. R. A. HAYNES, '96, of Clarksburg, W. Va., has been elected Vice-President of the West Virginia State Medical Society.

DR. G. CLARENCE PARCHER, '93, Saugus, Mass., is lecturer on pediatrics in the College of Physicians and Surgeons, Boston.

DR. F. T. HAUGHT, '88, who has been at Farmington, W. Va., for some years, has changed his place of residence to Mona, W. Va.

DR. F. A. PALMER, '96, has given up his practice in Leipsic, Kent Co., Delaware, and has moved to Sussex Co., in the same State.

DR. CHARLES W. WAINWRIGHT, '87, of Princess Anne, has been appointed a member of the State Lunacy Commission of Maryland.

DR. C. M. POOLE, '80, has a successful practice at Craven, N. C. He would be glad to hear from his old classmates of '78, '79 and '80.

DR. L. J. GALLUP, '98, who has a well established practice, was around the College for a few days in February renewing old acquaintances.

DR. L. BERLIN, '01, formerly one of the Assistant Physicians at Bay View, has moved to Norfolk, Va., where he has opened an office on Church Street.

DR. J. M. WALL, '96, of Naples, Texas, spent January and February about the College and Hospital studying the recent advances in medicine and surgery.

DR. ROBERT J. BLACK, '81, is Mayor of McKeesport, Pa. It is seldom indeed that a physician gets to be chief executive of a city and we want to congratulate him.

DR. JOHN O. McREYNOLDS, '91, of Dallas, Texas, was a visitor at the College in the early part of June on his way to the American Medical Association meeting at Saratoga.

DR. E. H. BOWLING, '91, is deputy collector in the U. S. internal revenue office at Durham, N. C. He says there is a good opening for a young man at his former place, Leester, N. C.

DR. S. L. TERRILL, '95, and DR. F. H. HALL, '97, are among the most successful eye and ear specialists in Dallas, Texas. All their friends among the JOURNAL's readers will be pleased to hear of their success.

DR. B. C. WADDELL, '93, of Scottville, N. C., is back at the College for a month's work in pathology and bacteriology. His nine years of practice have made but little change in him and his old friends could hardly believe that he had been away for so long.

DR. H. R. MCGRAW, '01, has settled in Denver, Colo., and has already succeeded in getting an unusual start in that city of many excellent physicians where success generally comes very slowly. He has an office in the Jackson Building and has recently been appointed Inspector of the State Board of Health.

The many friends of CLAY JOHNSON, who was one of the most popular men of the Class of '92, will be delighted to hear that he is the proud father of a little daughter who was born the latter part of February. The happy father is one of the many men whom we have sent to Texas and he has a large practice at Corsicana.

DR. JOHN RUHRAH and Mr. REEDY, '02, of the Phi Beta Pi Fraternity, were in Philadelphia on February 15, to represent their chapter at the installation of a chapter of their Fraternity at Jefferson Medical College. The new chapter started out with sixteen enthusiastic members. The exercises and the banquet which followed were held at the Bingham House.

DR. H. M. ORR, of La Salle, Ill., who spent some little time in the East this winter looking up surgery, holds quite a number of important positions. He is the Coroner of La Salle County, the surgeon to Illinois Central, the Chicago R. I. & L. and the Chicago, Burlington and Quincy Railroads; Surgeon to St. Mary's Hospital and to two large cement companies and two zinc companies. We should like to hear of all our boys holding such a goodly number of profitable positions.

DR. W. E. FITCH, '91, the founder and editor and business manager of the Georgia Journal of Medicine and Surgery, has sold his interest to his co-editor, Dr. St. J. B. Graham. Dr. Graham is now the sole proprietor and editor of the journal. DR. FITCH was a flying visitor at the College in January, and informed us that hereafter he will devote his entire time to the practice of his profession in Savannah, Ga. We must congratulate DR. FITCH on the sound character of the journal which he has built up and his successor has our best wishes.

THE biological laboratories of the H. K. Mulford Company have secured the services of JOSEPH J. KINYOUN, M. D., Ph. D., late Surgeon of the Marine Hospital Service and Director of the Hygienic Laboratory of the Marine Hospital Service at Washington.

Dr. Kinyoun is widely and favorably known at home and abroad as a sanitarian and scientific investigator, and has served the government on numerous occasions as special delegate to international medical congresses. Dr. Kinyoun received special instruction from Professors Koch, Behring, Pasteur and Roux of Paris and Berlin, as representative of the government, thus acquainting himself with the progress made in serum-organotherapy and in the investigation of infectious diseases. He is peculiarly fitted for the directorship he now assumes and under his administration there will be still further advances made in the field of biology as applied to medicine.

CASCARA EVACUANT.

THE ENERGETIC PROPERTY OF CASCARA SAGRADA
WITHOUT ITS BITTER PRINCIPLE.



CASCARA EVACUANT should not be confounded with the multitude of "tasteless" cascarias with which every physician is familiar. It presents unimpaired the laxative non-bitter glucoside of the true *Rhamnus Purshiana*. It is the most active, the most eligible, of all palatable preparations of Cascara Sagrada.

When we introduced it to our physician friends we predicted that it would prove a revelation. It was no idle prophecy. *The verdict of the profession is unmistakable.* CASCARA EVACUANT has fulfilled every promise made for it. **IT IS A REVELATION!**

(Supplied in pint, half-pint, quarter-pint and half-gallon bottles.)

LABORATORIES:
Detroit, Michigan, U. S. A.
Walkerville, Ontario, Canada.
Hounslow, England.

PARKE, DAVIS & CO.

BRANCH HOUSES:
New York, Kansas City, Baltimore, New Orleans, Chicago, London, Eng.; Montreal, Que.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, N. Y., Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S.	Ohio.	R. B. DONALDSON, D. D. S.	D. C.
E. PARMLY BROWN, D. D. S.	N. Y.	H. A. PARR, D. D. S.	N. Y.
A. L. NORTHPROP, D. D. S.	N. Y.	J. EMORY SCOTT, D. D. S.	Md.
E. L. HUNTER, D. D. S.	N. C.	C. L. ALEXANDER, D. D. S.	N. C.
W. W. WALKER, D. D. S.	N. Y.	M. M. MAINE, D. D. S.	Conn.
OSCAR ADELBURG, D. D. S.	N. J.	J. W. DAVID, D. D. S.	Texas.
G. MARSHALL SMITH, D. D. S.	Md.	A. C. BREWER, D. D. S.	Md.
C. M. GINGRICH, D. D. S., Resident.	Md.	J. ROACH, D. D. S.	Md.
J. HALL MOORE, D. D. S.	Va.		

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

W. W. DUNBRACCO, D. D. S.	J. K. BURGESS, D. D. S.	J. C. SUTHERLAND, D. D. S.
GEO. V. MILBOLLAND, D. D. S.	CHAS. THEBERATH, D. D. S.	
L. M. PARSONS, D. D. S.	HARRY E. KELSEY, D. D. S.	C. H. CARSON, D. D. S.
H. M. LEVER, D. D. S.	C. S. GORE, D. D. S.	L. F. PALMER, D. D. S.
C. R. STEWART, D. D. S.	L. D. CORIELL, D. D. S.	
H. H. HAYDEN, M. D., Demonstrator of Anatomy.		
C. F. BLAKE, M. D., Demonstrator of Anatomy.		

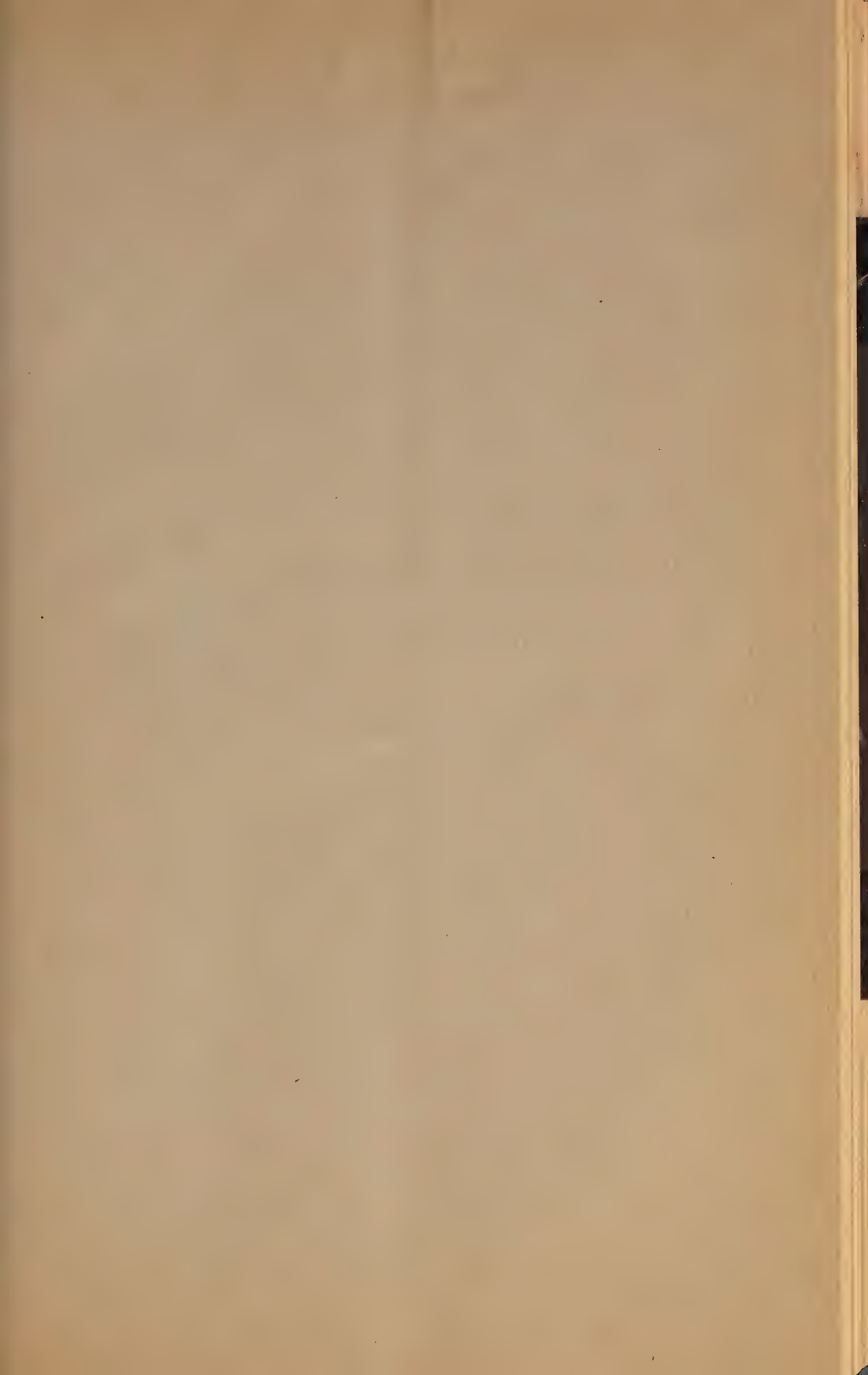
The Sixty-Third Annual Session will commence on the 1st of October, 1902, and continue until May, 1903.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.



College of Physicians and Surgeons OF BALTIMORE.

FACULTY

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- AARON FRIEDENWALD, M. D.,
Professor of Diseases of the Eye and Ear.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Medical Jurisprudence and Director of Pasteur Institute.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, A. B., M. D.,
Professor of Obstetrics.
- WM. ROYAL STOKES, M. D.,
Professor of Pathology and Bacteriology.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- O. HAMPSON JONES, M.B., O.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- HARRY FRIEDENWALD, A. B., M. D.,
Associate Professor of Diseases of the Eye and Ear.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MCLEARY, M. D.,
Associate Professor of Histology and Pathology.
- CHARLES E. BRACK, M. D.,
Associate Professor of Obstetrics.
- JOHN RUHRÄH, M. D.,
Clinical Professor of Diseases of Children.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Clinical Professor of Diseases of the Rectum.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MCGLIANNAN, M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- MELVIN ROSENTHAL, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- ALBERTUS COTTON, M. D.,
Associate Professor of Orthopedic Surgery.
- ARCHIBALD C. HARRISON, M. D.,
Demonstrator of Anatomy.
- GLENN M. LITSINGER, M. D.,
Demonstrator of Obstetrics.
- SAMUEL T. DARLING,
Demonstrator of Chemistry.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- JOHN MASON KNOX, JR., M. D.,
Demonstrator of Pathology and Physical Diagnosis.
- CHARLES B. CANBY, M. D.,
Demonstrator of Pathology.
- OTTO C. GLASER, A. B.,
Demonstrator of Embryology.
- L. H. HIRSHBERG, A. B., M. D.,
Demonstrator of Bacteriology and Assistant in Neurology.
- C. W. G. ROHRER, M. D.,
Demonstrator of Pathology and Resident Pathologist.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Assistant in Genito-Urinary Surgery.
- OTTO SCHAEFER, M. D.,
Assistant in Eye and Ear Diseases.
- HERMAN WESTHAL, M. D.,
Assistant in Surgery.
- W. EDWARD MAGRUDER, M. D.,
Assistant in Diseases of Children.
- L. J. ROSENTHAL, M. D.,
Assistant in Diseases of Stomach.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Table of Contents Page III.

Issued Quarterly

Price \$1.00 per year.

THE JOURNAL

OF THE

ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS
AND SURGEONS

BALTIMORE.

Vol. V

No. 3

OCTOBER, 1902

PUBLISHED AT

Baltimore and Eutaw Sts. Baltimore, Md.

ANNOUNCEMENT
OF
POST-GRADUATE COURSES
FOR
PRACTITIONERS OF MEDICINE

Beginning May 1st, 1903, and continuing for six weeks. These embrace courses in *Medicine* (including daily visits to the medical wards), *Pediatrics* and *Nervous Diseases*, *Surgery* (general, orthopedic, genito-urinary surgery and cystoscopy), *Gynecology*, *Operative Obstetrics*, *Ophthalmology* (including a course in the use of the Ophthalmoscope), *Otology*, *Laryngology*, *Pathology* (Demonstrations of fresh specimens and microscopic course), *Bacteriology* and *Clinical Laboratory* courses in the microscopic and chemical examination of the blood, urine, gastric juice, feces, etc., etc.

These courses *are entirely* practical.

A certificate of attendance will be given at the end of the course.
For schedule and further information apply to

DR. HARRY FRIEDENWALD, CHAIRMAN,

College of Physicians and Surgeons,

BALTIMORE, MD.

The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,

CATONSVILLE, MD.

REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
Announcement of Professor Aaron Friedenwald's Death,	65
A Brief Review of the Development of Obstetrics. (Concluded from No. 2.) DR. CHARLES EMIL BRACK,	66
Fractures of the Spine. DR. ARCHIBALD C. HARRISON,	76
The Value of Blood Examination in Surgery. DR. A. O. SCHOENIGER and DR. R. I. NEWELL,	79
The Puerperium. DR. ALFRED H. QUESSY and DR. CHARLES F. MERRILL,	84
Editorial,	89
Personal Notes,	iv, 91
Correspondence,	93

"OUR
LEADER."

Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.



All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,
MANUFACTURERS AND IMPORTERS,
300 N. HOWARD STREET, - - - BALTIMORE, MD.
PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES.

CLINICAL LABORATORY OF Dr. CHARLES E. SIMON.

Private instruction in Clinical Chemistry and Microscopy; in Normal and Pathological Histology. Facilities for original work.

Examinations of blood, urine, stomach contents, feces, tumor specimens, etc.

Chemical and bacteriological examination of drinking water, milk, etc.

1302 MADISON AVE., BALTIMORE, MD.

Personal Notes.

DR. D. S. FISHER, '84, is practicing at Reading, Kan.

DR. C. B. WISEMAN, '02, has a good practice at Henrietta, N. C.

DR. GEORGE E. ROBISON, '98, is secretary of the Utah State Medical Society.

DR. C. B. BRÜCKNER, '01, has been appointed District Physician at Newark, N. J.

DR. J. RILEY MCCOLLUM, '00, is assisting Dr. A. S. GRIMM, '85, at St. Marys, W. Va.

A CARD.

At the beginning of another season, we beg physicians to consider the advisability of sending more of their patients to us for prescriptions and sick-room supplies. We will waive matters of ethics and base our claims for additional patronage upon the excellent character of our work, the better results secured through concentrated efforts and upon the advantages a comprehensive stock gives us.

MICROSCOPICAL AND
CLINICAL SUPPLIES.

HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

LAPACTIC PILLS

R

Aloin, S. & D.	gr. $\frac{1}{4}$
Strychninae,	gr. $\frac{1}{80}$
Extr. Belladonnae,	gr. $\frac{1}{8}$
Ipecacuanhae,	gr. $\frac{1}{16}$

M: et ft. Pil. No. 1.

The best and most reliable laxative pill ever offered the profession. The formula and name were originated by us, and because of the freedom of our Aloin from any resin of aloes or resinified aloes, due to our manufacturing it ourselves, Lapactic Pills never gripe and never fail. This cannot be said of the many substitutes offered the profession and the trade. Hence, please specify on your prescriptions and orders

SHARP & DOHME

CHICAGO.

BALTIMORE.

NEW YORK.

NEW ORLEANS.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap has been used exclusively in this baby's bath from birth, and her perfect skin and luxuriant hair excite wonderful interest and admiration.

AS A NUTRIENT SOAP
FOR THE SKIN . . .

Resinol Soap

IS WITHOUT A
. PARALLEL.

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.,
SYDNEY, N. S. W.
Agents for Australasia.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

PROFESSOR AARON FRIEDENWALD

DIED

AUGUST 26, 1902.

A BRIEF REVIEW OF THE DEVELOPMENT OF
OBSTETRICS.

BY DR. CHARLES EMIL BRACK, '95.

(Concluded from No. 2.)

While the feeling against male assistance was becoming less pronounced and princesses and noble women employed obstetricians, yet the midwife still remained a powerful opponent; the more so as midwives were reaping the benefit of improvements; became more proficient and had the opportunity of handling more cases. They were being regularly instructed and examined. De la Marche published a book for midwives, consisting of questions and answers (quiz compend).

In Germany one Justine Siegermundin achieved quite a reputation. She had the title of Brandenburgische Hofwehmutter.

In Germany obstetrics and medical science in general were very much neglected. Schools did not exist. There were many individual teachers, but they lacked practical experience.

In Holland, however, we find a shining obstetrical light in Heinrich van Deventer, 1651-1724, a master of the subject, who published as a result of his experiences a scientific work, clear, concise and honest. He did not indulge in speculation, but confined himself to close observation, excluding everything that had no direct bearing upon the subject.

He describes position of womb in relation to other pelvic organs; the sacral curve and the pelvic angle. The technique of examining patient is excellent, with special reference to presentation, to beginning labor and prognosis. He lays special stress upon preserving the membranes and understands their function.

Friedrich Ruysch, 1638-1731, in a work of anatomical research describes the layers of the membranes and muscular structure of the uterus.

Van Hoorn of Sweden, 1661-1724, Stockholm, describes placenta prævia as a definite attachment in lower uterine segment.

In England obstetrics was largely in hands of midwives.

John Mowbray writing at this time, says:

"In France men only profess the business.

"In Germany and Italy, men and women promiscuously.

"In England and Scotland men are styled extraordinary midwives, being seldom or never called but in extreme cases of difficult and preternatural birth."

We cannot leave this period without mentioning Harvey, 1628, whose epoch-making discovery had its bearing upon obstetrics as upon general medicine. To him belongs the dictum "*omne vivum ex ovo*." He made studies of the development of the ovum, of gestation and fetal position. He holds forth against the midwives for hurrying labor by dilating parts and giving drugs and interfering with natural forceps.

De Graef, 1641-1673, demonstrated the difference between testes and ovaries (*testes muliebres*).

Needham, 1667, studied placental circulation; described the chorionic villi and the umbilical vesicles.

Malpighi, 1681, who studied development of ova of birds and whose illustrations are so good that they could be used to-day. Malpighi and De Graef used a microscope consisting of a simple lens.

Thos. Bartholini, 1616, added other results of observations both anatomical and physiological which had a decided bearing upon obstetrics.

Thus we find at the end of the seventeenth century obstetrics standing upon a solid foundation. Superstition and speculation have given way to facts and truth and better judgment.

Those, who came after, built up a wonderful scientific structure upon this foundation so well laid, but the greater glory belongs to the pioneers of the seventeenth century who, fighting against time-worn prejudices and long-established customs, found the truth and proclaimed it despite ridicule and opposition.

In the beginning of the eighteenth century, then, we find obstetrics as a science out of the swaddling clothes and walking unaided. We find obstetrics practiced as a specialty and many volumes of more or less original research written upon this branch of medical science.

These were no longer a jumble of theories but a collection of facts derived from practical experience and scientific investigation.

This new era is marked by the invention of the forceps. While the invention itself belongs really to the previous century, it did not become public property until many years later. The credit for this discovery, which revolutionized the practice of obstetrics, belongs to the Chamberlens, although the mercenary motives which deprived suffering women of its benefits for so many years will for all time condemn the inventors.

In a preface to his translation of Mauriceau's work Chamberlen, 1672, writes of his secret and says that he, his father and his brothers alone knew of a secret by means of which difficult head presentations can always be readily and easily delivered without danger to mother and child. He states further that he could not disclose the secret without materially injuring his associates.

The secret was finally sold in Amsterdam to several physicians and again sold by them. The money-making scheme continued and the College of Amsterdam in possession of the knowledge caused a law to be passed that no obstetrician should practice his art without having acquired this knowledge—for a consideration, of course.

Finally two public spirited men, Jacob de Vischer and Hugo van der Poll, acquired the knowledge of the forceps by purchase and made it public (1753).

In 1733 the forceps were made public in England and described by Edmund Chapman in an essay on midwifery.

There was some controversy about the Chamberlen forceps until, in 1818, a chest containing property of the Chamberlens was found and several pair of forceps discovered. The type was that of fenestrated blades with cephalic curve only and the English lock.

Johann Palfyn of Flanders, independent of Chamberlen, 1723, invented a forceps, the blades of which were solid and the handles did not cross; it proved not successful.

In 1731 Richard Manningham established a private maternity and advocated a public lying-in asylum and home for foundlings.

Fielding Ould, 1742, recognizes that forceps are not applicable

in greatly contracted pelvis; when the head is high or when external genitalia are greatly swollen.

Caesarean section he calls a detestable, barbarous, illegal piece of inhumanity and rather foreshadows the stand of English obstetricians on the question of Caesarean section and perforation.

The rivalry existing between English and French obstetricians greatly enhanced the advance of obstetrics.

Andre Levret, 1780, modified forceps and added the pelvic curve; his forceps is the prototype of the French forceps of later days, distinguished principally by the screw lock. As indications for forceps he cites: moderate disproportion of child's head and pelvis, hemorrhage, convulsions, atony, exhaustion.

He recognizes indication for Caesarean section when hand cannot enter pelvic brim from below.

Levret is undoubtedly the founder of a rational operative method.

Smellie (1760, England), a follower of La Motte, was the first to properly appreciate mechanism of labor by close observation of pelvic and fetal structure and of the changes in position during second stage of labor; by locating the sutures, the fontanelles of fetal head and the position of the ears.

He explodes forever the eighth month theory, i. e., that the child changes its position before birth.

He advocates the lateral position of the woman in labor, which is to-day the favorite in England.

The forceps is further improved by him and accurate directions for application are given. Smellie advocated application to sides of child's head over the ears.

In high position of head he recommends version; in low position, the forceps. If forceps fail, then perforation should be done.

He describes the delivery of extended arms in extraction and recommends forceps on the after-coming head.

In frank breech anterior foot should be brought down.

Wm. Hunter, 1746, strongly opposed Smellie's teachings and strongly condemned forceps, intimating that this instrument had done more harm than good. He states, however, that he has used the

forceps sometimes with advantage and "I believe never materially hurt a mother or child because I always used it with fear and circumspection."

The influence of so prominent a man no doubt largely restricted the use of forceps, but increased the number of perforations. Like most Englishmen he disapproved of Caesarean section.

His most important work is the "Anatomy and Physiology of the Pregnant Uterus," 1751-1774. Thirteen bodies of pregnant women came to autopsy and were not only carefully dissected and studied but beautiful plates in accurate detail were made of each case. The decidua externa and reflexa were shown in these plates and accurately described. He was assisted by his brother, John Hunter, in this work.

Johnson published a system of pelvic measurement by means of the hand with fingers extended and abducted.

Much credit belongs to Alex. Hamilton, of Edinburgh, and to Thos. Denman, 1733-1815, for their conservative attitude.

"Not all mistakes in practice are from ignorance; many occur from a too high opinion of art and too much confidence in our own dexterity; there is too little dependence upon the natural efforts and resources of the constitution." (Denman.)

He recommends leaving the case to nature, since many unusual positions of the head will terminate normally though labor may be protracted.

After version the case should be left to nature.

He mentions 30 cases of spontaneous evolution in transverse presentations. That this conservatism, however, was often carried too far is shown by the frequency of perforation.

In Germany at this period obstetrics was far behind England and France. The midwives still had the upper hand. This is shown by a decision of Charles V that in questionable cases the opinions of midwives were more weighty than those of surgeons.

First school for midwives established at Strassburg in 1605. We find mention of two men at this time, Deisch and Mittelhäuser, whose names became household words to designate incompetent and brutal

means for years afterward. They perforated, cut and tore. If version was performed they were astonished if the child lived; forceps were used with such violence that the instrument was frequently broken.

In 61 confinements 29 times were sharp instruments used, and 10 mothers died.

Toward the end of the eighteenth century we find obstetrics flourishing in Germany and many able men working in this field.

Johann N. Crantz of Vienna described signs and causes of uterine rupture.

Roederer and Stein of Goettingen were followers of Levret.

Stein, 1765, invented the pelvimeter and an instrument for measuring the fetal head. With the assistance of these instruments he was able to describe accurately deformities and give us the basis of a classification.

In 1784 a wing of the "Allgemeines Krankenhaus" in Vienna was devoted to obstetrical purposes and known as the "Allgemeines Gebärrhaus." Practical instructions were given here and an ordinance passed through offices of von Störk that no physicians be permitted to practice obstetrics unless he had attended a course of instruction in this hospital. The instructions were given on the manikin, on cadavers and at the bedside.

Stärk published the first obstetrical journal.

1777 marks the date of the first symphyseotomy by J. R. Sigault, Paris. The operation was performed upon a rachitic dwarf who had been delivered of four dead children. A. P. diam. was two and one half inches; head of child, three and one-half inches. The neck of the bladder was cut, leaving a permanent fistula. After 46 days the patient walked and was exhibited before the faculty, who honored the operators, Sigault and Lewy.

The truth about the case is that the operation left the woman in a dreadful condition, which did not advertise the new operation very well and excited much opposition. Sigault repeated the operation several times with indifferent results and finally abandoned it.

The operation was tried in other countries, but it was found to

be applicable only in a restricted number of cases and soon fell into disuse.

A star of the first magnitude appearing upon the obstetrical firmament was Bandeloque, Jean Louis, 1746-1810.

While Levret largely influenced the operative feature of obstetrics, yet his conception of normal labor entertained many erroneous ideas. It was in this field that Bandeloque achieved greatest success and wielded an influence that was not confined to France but extended to other countries. The work on these lines was inspired by his teacher Solayris de Renhac, whose lifework was cut short at an early age by phthisis, 1772.

Bandeloque's knowledge of the pelvis was accurate and his measurements form the basis of all others that followed.

He appreciated the importance of external palpation as a means of diagnosis.

His description of fetal positions and their mechanism shows a most accurate knowledge, though somewhat confusing owing to his voluminous classification. He recognizes 94 different positions, but shows a master hand in their management, so that many of his doctrines are accepted to-day with but little modification.

His description of versions is so complete and scholarly that it markedly influenced obstetric practice at the time and the operation became the one of choice at expense of the forceps.

The forceps was not neglected by him, however, and the Levret forceps received several modifications. His instructions and method of forceps operation were accepted for many years without change.

Bandeloque favored Caesarean section in preference to perforation and symphyseotomy. In fact, the opposition to the latter operation and to Sigault established a marked preference for the Caesarean section operation.

Another name to be linked with the progress of obstetrics at this time is that of Mathias Saxtorph of Copenhagen, 1740-1800, whose work was on a par with Bandeloque's.

Saxtorph among many others wrote an interesting paper on knots and torsion of the cord.

Lucas Johann Boer of Vienna, 1751-1835, who advocated strictly non-interference and looked upon labor as a perfectly natural and physiological process, wrote an interesting treatise upon puerperal fevers.

In opposition to Boer we find the teachings of Osiander, 1759-1822, who believed entirely in a scientific treatment of obstetrical cases. Osiander lacked the clinical experience of Boer and derived most of his practical experience from the delivery of difficult mid-wife cases. He brought the application and uses of the forceps to a high degree of perfection. By modifying the forceps then in use, increasing their pelvic curve and adding length and greater strength he was enabled by special manipulation to use the forceps on the head at the brim.

While Boer used forceps 19 times in 2926 cases and perforated in 6 cases, Osiander in 2540 cases used forceps 1016 times and did 111 versions, 21 extractions and 4 Caesarean sections.

Some of his deliveries lasted two hours, during which he made 100 tractions. One case is mentioned of 175 tractions, yet children were delivered alive and though after the forceps left permanent impressions upon cranial bones, yet no disturbance of mind or memory occurred according to Osiander's statements.

Osiander is the author of the most accurate and comprehensive history of obstetrics up to his own time.

von Siebold is responsible for the Maternité of Wurzburg, 1805, and instrumental in erecting maternité in Berlin, 1817. He belonged to the conservative school. He still further modified forceps and placed perforation in its proper place.

He advocated complete hysterectomy for cancer.

Justus Heinrich Wigand, 1769-1817, appreciated that abnormal labor was not always dependent upon pelvic conditions and unusual presentations, but often to disturbance of expulsive forces, which were amenable to therapeutic treatment. He urges that the obstetrician should be a well instructed general practitioner and advocates drugs, postural treatment and external manipulation.

To Franz Karl Naegele, Heidelberg, 1777, belongs the credit of

establishing our present conception of mechanism of labor. His most important work is that treating of pelvic deformities, especially those forms depending upon ankylosis of hip joint and pelvic exostosis. His influence extended generally all over the world.

D'Outrepont, 1775, is responsible for an extensive treatise upon perineal lacerations and his condemnation of the indiscriminate use of ergot, the dangers of which he well recognized.

Von Ritgen, 1814, studied pelvic planes and described the plane of greatest contraction at level of spines.

Carl Gustav Carus, 1827, gave us an important work on puerperium and its diseases and diseases of the new-born child.

Carl Wenzel was largely responsible for the acceptance of induced labor as a legitimate obstetrical procedure in contracted pelves and in eclampsia. He advocates the use of a sponge tent to induce labor.

Scholler, 1842, observed that the vaginal tampon is safer and an effective means of producing uterine contractions and cervical dilatation.

In France the credit for the best practical work and the most influential of any contemporary belongs to Marie Louise Lachapelle.

Mme. Lachapelle had but little knowledge of anatomy and physiology and her work was the result of close observation and experience in about 40,000 cases.

The extensive and confusing classification of 94 presentations as arranged by Bandeloque was simplified by her and reduced to 22. She had an accurate knowledge of diagnosis and of obstetrical difficulties and was a master of version. Her directions for the application of forceps are in vogue to-day and bear her name. The forceps are applied to the side of child's head and are introduced in the posterior quadrants of pelvis, the blade over lower ear is always introduced first and the second is made to assume its position over anterior ear by a spiral movement which still bears her name.

She recommended bleeding in convulsions.

De Kergaradec introduced auscultation of the fetal heart and recognized the placental souffle. He diagnosed the position of twins by auscultating the fetal heart.

Stoltz perfected the induction of labor.

Merryman wrote an interesting treatise on uterine dystocia.

Davis paid much attention to forceps and modelled different types applicable to many conditions.

James Y. Simpson wrote an important work upon pathology of placenta and puerperal fever.

Francis, James, Dewees and Meigs were the pioneer obstetricians in our own country.

When viewed at this time obstetrics furnishes a flourishing picture. The underlying principles were well understood; the indications for operative interference were clearly defined and many of the obstetrical operations well executed.

The further development was comparatively more gradual and more pronounced in details and in obstetric technique. Such a mass of work was being done, the field of vision so extensive, that it becomes difficult to select the more important additions and developments of the science.

We can appreciate the value of anesthesia, the importance of Tarnier's invention and its influence upon forceps delivery. We are aware of the far-reaching influence of the perfected microscope and the result of histological and bacteriological research. To mention the names of men who have achieved prominence in the field of obstetrics would consume more space than we have at command.

We can but mention briefly the names of Kilian, Rokitansky, Michaelis, Roberts, Neugebauer and Schauta, and their extensive work upon the deformed pelvis and the elaborate system of pelvic mensuration established by them.

External palpation and version was brought to its present status by the work of Burton, His and Pinard.

Porro, Muller and Sanger are responsible for the good results obtained by the Caesarean operation as performed to-day.

Our present knowledge of puerperal sepsis dates back to the essay of Oliver Wendell Holmes on the "Contagiousness of Puerperal Sepsis" (43), the observations of Semmelweiss in the Vienna Hospital (46), Sir James Y. Simpson's paper on the "Analogy of Puer-

peral and Surgical Fevers" (50) and the discoveries of Lister and Pasteur.

From a position of ignominy and neglect obstetrics has to-day achieved a distinction quite on a par with medicine and surgery, and in every first-class medical school a thoroughly practical course of instruction is given.

The midwife is still an important factor and in European countries is often a well trained and competent individual and a graduate in some obstetrical training school.

It is to be deplored that in our own country there is no legal restriction to control this practice and that any woman, more or less ignorant of the very fundamental principle of obstetrics, as a means of livelihood, when other things have failed, can practice midwifery without license and without any training whatever.

BIBLIOGRAPHY.

Engelmann.—Labor Among Primitive People.

Hippocrates.

Raymond.—History of Medicine.

Siebold.—Geschichte der Geburtshülfe.

FRACTURES OF THE SPINE.

By Dr. ARCHIBALD C. HARRISON.

Of all the candidates for pity which enter our surgical wards, those with broken backs are perhaps the most deserving. A large majority are hopeless from the beginning, and those who are fortunate enough to escape early death from the immediate effects of the injury, can be promised only a life of unutterable misery extending over a period of a few weeks to a few months. No sadder chapter can be found in surgical annals than that which deals with these unfortunates. This does not apply to those cases of spinal injury in which the evidence of compression of the cord is absent or but partially developed. These belong in a different class. They are much more hopeful and a different line of action may be adopted. It is that class which presents

a definite, palpable injury, the so-called fracture-dislocation, with more or less complete suppression of the function of the spinal cord below the point of injury. During the past two years there have been many cases of spinal injury in the City Hospital, of which the following may serve as types:

(1) S. P., white, male, laborer, aged 46. July 25, caught under a heavy gate. Admitted same day. Evident deformity in lower dorsal region. Complete paralysis below umbilicus. No reflexes; no sensation. Laminectomy: 11th and 12th dorsal and 1st lumbar laminae removed. Cord pulpy. No improvement. Died August 1.

(2) W. S. C., white, male, painter, aged 28. August 28 fell from house. Admitted same day. Diagnosis, broken back. No operation. Died September 4.

(3) A. G., white, male, aged 52. December 17, crushed under a heavy steam coil. Admitted same day. Large contusion over lumbar region. No evidence of pressure or other disturbance of cord. Diagnosis, fracture of 2d lumbar vertebra (?). Discharged September 31 in good condition.

(4) G. S., white, male, painter, aged 19. Fell from bridge April 4. Admitted same day. Right leg fractured. Deformity in lower dorsal region. Complete paralysis of lower extremities and no reflexes. Sensation above knees, with priapism. Laminectomy: 8th, 9th and 10th dorsal vertebræ involved. Cord somewhat lacerated from fragments of bone. Trophic disturbances appeared early in this case and subsided rapidly. Left the hospital June 25. At this time his general condition was good. The fracture of leg had united and there was but one small decubitus, which was soon healed. He had fair control of the bladder and rectum, with considerable increase in sensitive area, but no voluntary motion in legs. Since then his general health has been good. At this writing (May 22, 1902) there is no marked improvement. Reflexes greatly exaggerated, but no voluntary motion in legs.

(5) C. T., white, male, laborer, aged 23. On June 11, while felling timber, was caught beneath a falling tree. Admitted to hospital June 14. Marked deformity in mid-dorsal region. No sensation. No reflex, and complete paralysis below costal arch. Operation same day.

Laminæ of 7th, 8th and 9th dorsal vertebræ removed. Two or three fragments of bone had penetrated the dura, but the cord seemed in fair condition. He was removed from the hospital July 17, up to which time he had run the usual course of broken backs, there having been no improvement in a single symptom. The final outcome is not known.

(6) A. M., white, male, elevator boy, aged 18. July 15 caught in elevator. Admitted same day. Marked deformity in lower dorsal region. Complete paralysis and absence of reflexes and sensation below costal arches. Sub-conjunctival effusion of blood, emphysema of face, neck and upper thorax, and marked œdema of lungs. Owing to his condition no operative procedure seemed warranted at this time. By August 15 he had recovered from all his symptoms save those of cord compression, which remained absolute, in addition to which there were the usual concomitants. With the hope of possible benefit, laminectomy was now performed. The 11th dorsal was found crushed and pushed well out to the right side, making two sharp angles with the cord. Sufficient of the body was removed to allow the cord an easy bed and also the laminæ of the 10th, 11th and 12th dorsal and a portion of the 1st lumbar. No improvement followed and on January 30 a pyelonephrosis terminated his miserable existence.

(7) Mary J., negress, aged 19. Received a pistol shot September 7 which entered the 6th intercostal space at the posterior axillary line and ranged backwards and downwards. The function of the cord was entirely suppressed below the costal arch and operation was declined because it was deemed certain that the cord was divided. She died September 25 and the necropsy showed that the ball had passed through the body of the 8th and lodged against the lamina of the 9th dorsal vertebra, completely severing the cord.

There is good reason to believe that operation accomplished all of which it was capable in these cases, in that all sources of compression were removed and union per primam was obtained in each instance.

This is indeed a lamentable exposé of human misfortune and medical impotence, but I would have the reader distinctly separate the class of cases here referred to from those in which evidence of compression is

incomplete or comes on at a later date, for, in these latter, surgery may justly claim many signal victories.

In view of this report, the question may reasonably be asked: "Is operation justifiable when results are so meagre?" If we consider the fact that such cases are otherwise absolutely hopeless, and that in a certain few good results can be obtained, I think we may properly answer in the affirmative.

Cases 1 and 4 occurred in the service of Dr. I. R. Trimble; 2 and 3 in that of Dr. Chas. T. Blake, to which gentlemen I am indebted for the privilege of reporting them.

THE VALUE OF BLOOD EXAMINATION IN SURGERY.

By DR. A. O. SCHOENIGER, '02, AND DR. R. I. NEWELL, '02.

Though but a small field of the physiology and pathology of the blood has as yet been explored, it has placed in the hands of the surgeon facts which, when observed and rightly interpreted, do much to aid him in diagnosis, prognosis and treatment. There is probably no one department of clinical diagnosis in which such rapid advances have been made as in the systematic examination of the blood. The value of such examination depends: 1, upon correctness of technique in the methods employed; and 2, upon a proper application of the knowledge gained thereby. In making deductions from the conditions found by blood examination, it will be well to consider the individual as a unit, rather than one of a class.

In all operations that are not immediately imperative, it is advisable to ascertain the time required for the coagulation of the blood; since in hemophilia, jaundice and pernicious anemia an uncontrollable capillary hemorrhage may be encountered. The means of determining the coagulability is by Wright's coagulation tubes. Normal blood will be found to coagulate in two to three minutes. The hemoglobin also is a most valuable index of the patient's condition; many surgeons requiring, where the operation can be postponed, that by medical and dietetic means the hemoglobin should be brought to 30 per cent or over, thus diminishing the amount of shock following hemorrhage.

The regeneration of the blood after operation depends upon several factors: (a) the amount of blood lost in a given time; (b) the age (extremes bearing loss of blood poorly); (c) the sex (females standing loss better than males); (d) the nutrition of the patient; and (e) the presence of other diseases. Bierfreund observes that after operation for malignant disease, the blood is slower in regenerating and never reaches as high a point as before the operation. After ordinary operations the blood regenerates in from five to twenty days. Failure to do so generally points to some deep-seated malignant trouble, or to a concealed or secondary hemorrhage, one of the earliest signs of the latter being an increase in the leucocytes and a decrease in the red cells and hemoglobin. Other conditions being equal, slight hemorrhage has a tendency to stimulate the blood-forming organs. The blood may have an apparent large percentage of hemoglobin, due to its concentration from abstraction of the watery elements, as in dysentery, etc.

The count of the red corpuscles is of no less importance in making out obscure hemorrhage, as in trauma of the liver, spleen or kidney; ruptured aneurysm; ectopic gestation; and in the differentiation between hematothorax and pleurisy, etc. In cases of shock the blood count is useful to distinguish between that form caused by cerebral anemia following hemorrhage, and the type caused by compression or concussion. In the variety arising from hemorrhage, a salt infusion would be indicated, while in shock from compression or concussion an infusion might be harmful.

In counting the red corpuscles after hemorrhage, it must be remembered that at first only the quantity and not the quality of the blood is altered; thus immediately following hemorrhage, the count may be normal. The alteration in the blood takes place with the absorption of the fluids from the tissues, thus diluting the corpuscular element, and by the degree of dilution may be estimated the amount of hemorrhage which has taken place. In this connection let it be stated that often valuable information can be obtained by the simple examination of a fresh specimen. In fact, the value of this procedure cannot be overestimated when we consider the directions which it gives us for further examination.

As a point of differentiation the surgeon may find the well-known reaction of Widal in typhoid, or the test of Williamson in diabetes of no little value. The Justi reaction in syphilis has been proven of great accuracy, and may be of value as a diagnostic agent. The positive reaction consists in the marked fall in percentage of the hemoglobin, occurring from twelve to twenty-four hours after an inunction of mercury.

Numerous bacteria and parasites have been found in the blood and may be useful at times in giving a prognosis or making a diagnosis. Of the parasites, the several forms of malaria may be distinguished; the *Filaria sanguinis hominis* may be found and classified according to the time at which it is observed to be circulating in the blood. Of the bacteria, the *Spirillum recurrentis* may be present in the circulation and may be demonstrated in a fresh specimen. In infections of anthrax, the bacillus is often found in the blood, or demonstrated by inoculating mice with the infected blood. The typhoid bacillus has been found; also the bacillus of glanders. In tuberculosis the bacilli are occasionally found in the blood and are an evidence of the miliary type of that disease. Of no little prognostic value are cultures made from the blood in septic and pyemic conditions; the presence of the *Staphylococcus pyogenes aureus* or the *streptococcus* indicate a fatal termination. Cultures from the blood may be easily made by drawing off a few cubic centimeters of blood, with a hypodermic syringe, from a vein in the arm, and smearing it on blood serum, which is then grown in a thermostat.

Before taking up the pathological forms of *leucocytosis*, it will be well to remember the physiological conditions in which a leucocytosis may be found: as in the new-born infant; during gestation; after exercise, eating and massage. In making leucocyte counts after *operation*, another fact to be borne in mind is, that leucocytosis may be the result of anesthesia or shock.

The leucocyte count is of value: first, in diagnosing abscesses or deep-seated suppurations; secondly, by systematically counting the leucocytes, it may be determined whether the process is declining or advancing, and whether or not operative measures are indicated. This is well shown in typhoid cases which are complicated by perforation;

here a steady increase in the leucocytes, from five to seven thousand up to between fifteen and thirty thousand may be found. This characteristic blood change is often demonstrable before any other marked symptoms occur. The same is true of appendicitis, the early recognition of which is important. Here the blood should be examined every four to six hours during the first two days. Even if not indicated by the local symptoms, a leucocytosis of over 18,000 should prompt an exploratory operation.

The count of leucocytes is independent of the amount of pus present or its location, being modified largely by the resisting power of the patient and the virulence of the infection. Thus a low resisting power and a high degree of infection would not produce any leucocytosis, and this, especially when associated with severe forms of suppuration, would give a fatal prognosis. Other things being equal, as a rule, the greater the leucocytosis the more virulent the infection. Occasionally leucocytosis may be absent, owing to the sterility of the pus, or where the pus has been walled off. In these two forms the absence of leucocytosis signifies that the process is at a standstill. This is especially true of hepatic abscesses, which are often sterile or walled off. The leucocyte count is also a valuable measure in determining the variety of an infection as to organisms. Thus a leucocytosis would exclude tubercular infection, or would indicate that there was a secondary infection. In post-operative temperatures the leucocyte count will show whether they are of nervous origin or due to deficient drainage or sepsis.

The variety of leucocytosis in suppurative conditions is usually that of the polynuclears. This fact is very valuable in differentiating between suppuration and other conditions, *e. g.* cancer. In this we find the leucocytosis affecting the mononuclears, and are thus enabled to differentiate a cancer from an ulcer of the stomach, or a cancer of the uterus from hemorrhagic metritis. The early recognition of intestinal obstruction is made possible by means of the leucocyte count. In this there is always a leucocytosis of over 20,000. The mistaking of typhoid fever for pyosalpinx may be obviated by a proper blood examination, and so may many other errors in diagnosis.

The foregoing is but a brief outline of the facts which the conditions and reactions of the blood place in the hands of the surgeon, and which, if utilized, may materially aid his judgment. It must be admitted, however, that the surgical aspect of blood examination has been sadly neglected, for as yet there has been little investigation in this special field. There must be a reason for this. Surgeons are too apt to disdain anything which is purely medical, and since blood examination has been considered by many as belonging to medicine rather than surgery, it has not received much consideration at their hands. Many mistakes have been made, but none greater than this. The examination of the blood is no more a branch of medicine than it is of surgery. It is simply a department of clinical diagnosis; and clinical diagnosis belongs alike to medicine and surgery. There is just as much importance attached to a careful consideration of the blood, before and after an operation, as there is to an examination of the urine or a certain discharge.

But this is not the only reason. Many who have ventured on this means of diagnosis have met with disappointment, and as a consequence have denounced it. This is due to the fact that such are not sufficiently versed in blood work to enable them to arrive at correct conclusions, which is proven by the argument which many put forth; namely, that it takes too much time to make a proper blood examination, thus causing a delay which often cannot be afforded. A greater *experience* will demonstrate the *falsity* of this statement. There is another reason. Some surgeons expect *too much*. We cannot see the whole world through a telescope, neither can we see an entire disease by looking through a microscope.

The value of blood examination depends not upon *one* examination, or the condition of the blood *in* that examination, but rather upon the series of changes demonstrated by a *number* of examinations. This taken in conjunction with the *symptoms* at the time of the examination, is an aid, the value of which none dare to dispute. As Bloodgood says: "To interpret correctly the value of the blood count, especially the leucocyte count, it must be considered as one of the various *symptoms*, and it is of the utmost importance that it should be judged in relation to the duration of the other symptoms."

Therefore, let us consider the examination of the blood simply as *one* of the guide posts which is to direct us along the tangled path of medicine and surgery, and *only* as one—"but then the *onlys* make up the mighty all."

THE PUERPERIUM.

By DR. ALFRED H. QUESSY, '02, AND DR. CHARLES F. MERRILL, '02.

The puerperium is the convalescence from child-birth. As Lusk aptly defines it, it is the border-land between health and disease. The puerperal state, in a strict sense, is physiological, but at other times and under other circumstances the variety of conditions is such, says Schroeder, that it would be regarded as pathological.

It is not the object of this paper to exhaustively discuss the puerperium, but to take it up in the light of the statistician, indicating such points as appear to have some bearing on the abnormal perperium, and thereby to try to bring out something which, we trust, may prove in some measure instructive as well as interesting.

Our work is based on a review of the histories of 150 cases at the Maryland Lying-In Asylum. The histories were examined, and each of the 150 cases tabulated as regards the following points: para, age, color, position, labor (spontaneous and instrumental, and its duration), number of persons examining, primary rise, abnormal temperature and its given cause, lactation, the number of days the mother spent in bed and the number spent in the hospital, lacerations, maternal deaths, and condition of the pelvic organs on discharge.

These will be referred to with the exception of the number of days spent in bed and in the hospital respectively.

The scope of this paper, then, is to draw conclusions from the various abnormal puerperia met with, by considering their potent factors, first individually, and second collectively.

The individual consideration is intended to show the influence of color, position, examination, etc., upon the abnormal puerperium. The collective consideration studies each of the abnormal puerperia with their assigned causes, and also those cases which were abnormal with cause unknown.

The "primary rise" will also be discussed.

I. NORMAL AND ABNORMAL PUERPERIA.

They are based on the state of the temperature. 114, or 76 per cent, of the cases had a normal puerperium, or in other words, the temperature of each one of these cases was below 100.4 except the primary rise when it occurred. The other 36 cases, or 24 per cent, showed an abnormal puerperium, *i. e.* the temperature was above 100.4, with or without a primary rise. These 36 abnormal cases are the ones we shall consider.

Influence of Age on the Puerperium.—In tabulating the cases as to age, it was thought advisable to group the cases between certain ages. Thus we have taken the cases between the ages of 14 and 18 inclusively as one group, those beyond the 18th up to and including the 22d year, and in the same manner those between the 22d and 26th, 26th and 30th, 30th and 35th, respectively.

Of the 24 cases, the ages of whom ranged from 14 to 18 years, 3, or 12.5 per cent, showed an abnormal puerperium. Of the 55 cases whose ages were between 18 and 22, 19, or 34.5 per cent, had abnormal puerperia. Of the 42 cases whose ages were between 22 and 26, 8, or 19 per cent, showed abnormal puerperia. Of the 18 cases whose ages were between 26 and 30, 4, or 22.2 per cent, were abnormal as to the puerperium. Of the 6 cases with ages between 30 and 35, 2, or 33.3 per cent, were abnormal. The age was not given in one case, but the case was normal. One of the 3 abnormal cases, first mentioned between the ages of 14 and 18, was an emergency case.

Conclusions.—From these figures it would seem, if age alone be considered, that the most favorable time is before the 18th year, especially when we consider that one of the abnormal cases was an emergency case in which the conditions were very unfavorable, and which, had these conditions not existed, might easily have been normal.

As to Color.—There were 111 whites, 32 blacks, and 4 mulattoes. Of the 111 white cases, 24, or 21.6 per cent, had abnormal puerperia. Of the 32 black, 10, or 31.25 per cent, had abnormal puerperia. Three of the 4 mulattoes had normal puerperia, and one was abnormal. In 3 cases, the color was not mentioned, 2 of which had normal puerperia and one an abnormal puerperium.

Conclusions.—From this we see that the lowest percentage of abnormal cases occurred in the whites, the highest in the blacks. We are unable to give any explanation, as all cases, regardless of color, undoubtedly received the same care during labor and the puerperium. The mulattoes were only 4 in number and do not furnish sufficient ground to draw conclusions.

As to Parity.—The large majority of the cases were primipara, explained by the fact that all of the cases were hospital patients. Of the 111 primiparae, 27, or 24.3 per cent, had abnormal puerperia; one of these was questionable as to the parity. Of the 21 cases which were 2d para, 7, or 33.3 per cent, were abnormal. Of the 5 cases which were 3d para, 1, or 20 per cent, was abnormal; this abnormal case was due to a clot; the woman was 26 years old and belonged to the black race. Of the balance of the cases, 7 were 4th para, 3 were 5th para, 1 was 6th, and 1 was 9th para, and all had normal puerperia.

Conclusions.—The primiparae seem to make a better showing than the multiparae, and if the questionable case were to be excluded, the percentage of abnormal cases would be still less in primiparae. Parity, and other conditions more apt than parity to be causative of an abnormal puerperium, may coexist, and thus parity alone cannot furnish any definite conclusions.

Influence of Presentation.—99 cases presented as L. O. I. A.; 22, or 22.2 per cent, of these had abnormal puerperia; 39 as R. O. I. A., of which 9, or 23.1 per cent, showed abnormal puerperia; 2 cases as L. O. I. P., which were equally divided as to the normality and abnormality of the puerperium, and the same can be said of 4 cases which presented as R. O. I. R. There was 1 case each of L. M. I. A. and R. M. I. A., both being followed by a normal puerperium. Two cases of L. S. I. A. had one normal and one abnormal puerperium. A case of twins, R. O. I. A. and L. S. I. A., had a normal puerperium. The presentation was not known in the emergency case. One normal case presenting as R. O. I. A. had a Justo-minor pelvis. There were two slightly contracted pelvises, one of which was L. O. I. A., which had an abnormal, and the other R. O. I. A., which had a normal puerperium. One L. O. I. A. was complicated with a prolapsed cord, in which case an abnormal puerperium followed.

Conclusions.—These figures and notes are given mostly for the sake of completeness. Two of the more frequent presentations, L. O. I. A. and R. O. I. A., might alone be taken for statistics; the rarer presentations being too few to be of any consequence. The percentages for abnormality in the two presentations are 22.2 and 23.1. But, in our mind, presentation by itself, and especially that which is common, is just as apt to be normal as abnormal, and vice versa, and other factors must by far surpass it in importance. A rarer and more difficult presentation may call for an operative procedure, and in such a case instrumentation, and not presentation, is a more important factor in determining the character of the puerperium. If our figures on presentation must alone be considered, then rare presentations are the most apt to be followed by abnormal puerperia, and the percentage we find to be 50.

Influence of Labor on the Puerperium.—135 cases were spontaneous, 15 were instrumental. Of the 135 cases which were spontaneous, an abnormality was shown in 35 cases, or 25.9 per cent. Of the 5 cases in which high forceps were used, in only one, or 20 per cent, did an abnormal puerperium occur. Low forceps were used in 8 cases, medium in one, and both high and low in one, and in none of these did an abnormal puerperium occur.

As notes of interest we might add that among the spontaneous cases there was one premature labor, the fœtus being dead, which was followed by a primary rise, but the puerperium was normal; one oblique pelvis due to dislocation, which case was followed by no primary rise, but an abnormal puerperium; two cases in which the placenta was removed manually, there being no primary rise in either case and a normal puerperium in both.

In one of the cases in which high forceps were employed, the pelvis was a flat rachitic, and this was followed by a primary rise, but a normal puerperium.

Conclusions.—Instrumentation, we believe, is more causative of an abnormal puerperium than presentation; more so also than spontaneous birth, the chances for infection and constipation being greater. It is well to note that of the 15 operative cases we have just mentioned, only one showed an abnormal puerperium and this was due to bowels. This

speaks well for the technique used at the Maryland Lying-in Asylum for instrumental labor. Of the spontaneous labors, hardly anything can be said. 35 of our 36 abnormal puerperia occurred after spontaneous labor. This we believe is accidental. The chief known causes for our abnormal puerperia, as will be seen, are bowels and breasts, and these causes may occur independently in spontaneous and instrumental labor, bowel disturbances probably more frequent in instrumental.

Influence of Examinations on Puerperium.—One case was not examined and was followed by an abnormal puerperium; this was the emergency case. 50 cases were each examined by two persons, 9, or 18 per cent of which were followed by abnormal puerperia. 97 were each examined by more than two persons, and there were abnormal puerperia in 26, or 26.8 per cent of them. Two were each examined by one person, and in each a normal puerperium followed.

Conclusions.—Examinations influence abnormal puerperia in that there is more chance for infection if the examinations be frequent. Our figures bear out this statement by indicating that the fewer persons who examined each case, the greater were the chances for a normal puerperium, provided we exclude the case which was not examined, and this was the emergency case.

Of the 2 cases of infection, one was not examined and the other was due to a retained clot. It seems to us that the abnormality in these 2 cases, as due to frequent examinations is excluded ipso facto.

Influence of the Duration of the 2d Stage on the Puerperium.—Of all the cases, there were 75 in which the duration of the second stage was 1 hour or under, and 16 of these, or 21.3 per cent, showed abnormal puerperia. The duration of 2d stage was 2 hours or under in 46 cases, and of these 15 cases, or 32.6 per cent, were abnormal. Of the 14 cases in which the 2d stage was 3 hours or under, 2, or 14.3 per cent, showed abnormal puerperia. The balance of the cases were distributed to such an extent that we considered it to be of little use to note them here.

Conclusions.—The duration of the 2d stage, per se, is not of as much importance in influencing the nature of the puerperium as it is in influencing the occurrence of the primary rise, and this latter point will be considered more at length later on.

(To be continued.)

WILLIAM S. GARDNER, M. D., EDITOR,
1012 McCulloh Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER,
Mt. Washington.
Telephone, C. & P., Tuxedo, 984.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

THE ETIOLOGY OF THE SUMMER DIARRHEAS OF INFANTS.

Baltimore seems to be a favorable place for the study of the bacteriology of the diarrheas of infants. The painstaking work of Booker, from 1886 to 1897, is familiar to every laboratory worker the world over. We are now fortunate in having another fine piece of work done here.

Messrs. C. W. Duval, of Annapolis, and V. H. Bassett, of Baltimore, publish in a recent number of *American Medicine* a preliminary report of work done in the Laboratory of the Thomas Wilson Sanatorium and the Rockefeller Institute of Medical Research. The work was done under the direction of Dr. Flexner, Professor of Pathology at the University of Pennsylvania. Dr. J. H. Mason Knox, of our College, is the physician in charge of the Sanatorium. If we are to give credence to the reports of the lay press Dr. Welch, of the Johns Hopkins University, has watched the work with great interest.

Escherich, in 1886, gave an impetus to the study of the intestinal bacteria by his work on their relation to the physiology of digestion. Since that time he has contributed many other articles, as have also Baginsky, Lesage, Hayem and Booker. It would be impossible to mention here all the workers in this field, nor can we give the results of their work.

In 1898 Shiga, in Japan, described the bacillus of dysentery. This organism has been studied and identified as the cause of the dysentery of adults by Flexner and Strong, in the Philippines, by Kruse in Germany, and in the sporadic dysenteries by Vedder and Duval in this country. Celli and Escherich have both tried to identify organisms described by them as the Shiga-Flexner bacillus.

It remained for Duval and Bassett to connect this organism with the summer diarrheas of infants, as the etiological factor. They isolated it in twenty-five cases of summer diarrhea. The isolated organism gave the agglutinative reaction with the blood serum of the patients from which they were secured, with the blood serum of other infants suffering with diarrhea, with the serum from adults with acute dysentery and with the antidysenteric immune serum.

A full account of their work will appear in the *Journal of Experimental Medicine*.

Mulford, of Philadelphia, has had the immune serum made in his laboratory, and it is to be hoped that the fruit of these investigations will be the practical application of the serum to the treatment of summer diarrheas. It would seem, however, only admissible to treat such cases as had shown the agglutinative test with their blood serum.

Mr. Duval is in the graduating class of the University of Pennsylvania and Mr. Bassett in the same class in the Johns Hopkins University. The JOURNAL wishes to congratulate them on their magnificent work and to point to it as an example of what fourth year medical students may accomplish during their vacation. R.

THE INDEX MEDICUS AND THE CARNEGIE INSTITUTE.

Dr. Gould, editor of *American Medicine*, gives voice to a sentiment, in an editorial note of a recent issue of his journal, that every medical paper throughout the land should echo. Every medical worker should follow up his suggestion.

He regrets, as we all do, that the *Index Medicus* was stopped through someone's ideas of economy. This is not the place to discuss that part

of the subject. Neither is it the place to discuss the usefulness of the *Index Medicus*. Suffice it to say that it placed America where it should be, at the front, and that its lapse has made us take a back seat.

Dr. Gould suggests that every physician write to the Trustees of the Carnegie Institute and ask that they see to it that the *Index Medicus* is taken up where it stopped and is completed to date and kept going. We call on our Alumni to help this cause along. R.

Personal Notes.

DR. H. S. WILSON, '95, of Smoke Run, Pa., was a visitor at the College the second week in June.

DR. G. KIRBY COLLIER, '00, has been practicing in Wilmington, N. C., since he left the City Hospital.

DR. W. E. NORTON, '93, of Savannah, was at the college recently. He has a fine practice, good health and a beautiful wife.

DR. C. D. EVANS, '81, surgeon major of the Nebraska National Guard, is in charge of the new hospital at Columbus, Nebraska.

DR. R. S. MARTIN, '81, Stuart, Va., is president and DR. R. SUMPTER GRIFFITH, '86, Basic City, Va., is vice-president of the Medical Society of Virginia.

DR. B. R. BRYANT, '81, visited the college recently. He has an excellent practice at Kaskoo, Va., and would be glad to hear from any of his classmates.

DR. ELLIS CLARENCE GAREE, '90, died from typhoid fever August 30th, aged 41. He was a health warden of the city and president of the Southwest Baltimore Improvement Association.

We received recently a copy of the Richmond News, in which was published a history of the fight made by the Medical Society of Virginia

to raise the standard of the profession and also the portraits of the present examining board. Among these we were pleased to see DR. R. M. SLAUGHTER, '79, Alexandria, DR. R. S. MARTIN, '81, Stuart, DR. A. S. PRIDDY, '86, Marion, and DR. O. C. WRIGHT, '93, Jarretts.

The initial number of the Old Dominion Journal of Medicine and Surgery has been received. The Journal is a quarterly founded by the Alumni Society of the Medical College of Virginia. Its seventy-four pages are filled with live matter well arranged and well printed. DR. GREER BAUGHMAN, editor, DR. A. B. GREINER, associate editor, and DR. CHARLES R. ROBINS, business manager, will conduct the new venture. We wish them abundant success.

DR. RUSSELL BALLUM FREEMAN, '92, died of appendicitis, March 12, 1902, at Denver, Colorado. DR. FREEMAN was born in Milton, Queen County, Nova Scotia, Oct. 12, 1860. After graduating at the local schools he was associated with his father in the lumber business until 1889, when he entered the College of Physicians and Surgeons, graduating in 1892.

The following resolutions were adopted at a special meeting of the staff of St. Anthony's Hospital. They were prepared by a committee consisting of DRS. C. P. CONROY, H. W. ROVER and H. L. TAYLOR.

"Whereas, on March 12, 1902, death claimed another prominent member of the medical profession of Denver in the person of DR. RUSSELL B. FREEMAN, his professional associates on the staff of St. Anthony's Hospital, of which he was an honored member, desire to publicly express their appreciation of his personal qualities both as a physician and as a man.

"He was a physician of the highest attainments, beloved by his patients, kind and skillful, uniting in his nature those virtues which raise the profession of medicine from the mercenary to the humane. As a man and a citizen he was respected and esteemed by all who had the privilege of knowing him.

"Resolved, That the staff of St. Anthony's Hospital does hereby express its profound regret and sorrow at his untimely death.

"Be it further resolved, That a copy of these resolutions of condolence be forwarded to the city press and the bereaved family."

SOME FEATURES OF MEDICAL AND SURGICAL STUDY IN
LONDON AND BERLIN.

BY DR. A. S. GRIMM, '85, ST. MARY'S, W. VA.

The saying that "Great bodies move slowly" applies to medical and surgical study in London most appropriately, although I do not mean to say by this that these studies are not thoroughly taught here, but on the contrary I wish to emphasize the fact that they are most perfectly taught.

John Bull here is the same characteristic John Bull as elsewhere. He does not take hold of some new theory or remedy because it is new until he thoroughly investigates its merits and if it appeals to him as good he adopts it with a firm and lasting grasp and if not, he rejects it altogether.

The professors, in taking their classes through the wards, take very great pains to give them thorough clinical instruction in auscultation, percussion and the usual physical diagnostic methods of making diagnosis.

Nothing is gone over hurriedly, but a careful examination is made of each patient and all points of any interest are gone over, every vital organ of the body being examined.

I have seen Sir Thomas Barlow of the University Medical College and ex-Physician to Queen Victoria, spend a half hour around the bed of one patient in having the students examine him and then interrogating them on all points of interest relative to the case.

Each member of the class is thus taught to utilize his theoretical training in making microscopical and urinary examinations and of pathological specimens in general, and in this way he is thoroughly trained and grounded in physical diagnosis.

The result of this is that the English physician and surgeon is a good diagnostician and its fruits are daily seen in the hospitals, as it is very rare indeed for an operator to fail to find his diagnosis verified when operating.

The English surgeon does not impress one as being a rapid operator, although I have seen some very rapid work done by such men as Bland

Sutton, W. H. Tate and some others, however, he does impress one as being a conscientious worker delving after truth and not to make a display or show of his work.

By having tickets of admission to several large hospitals one sees work done by a great variety of different men and gathers ideas which may differ somewhat in detail, but which tend to give him a broader scope of thought and utility.

Thus Prof. Barker of the London University Medical College uses linen thread for intestinal sutures and other abdominal work. Prof. Ballance and others of St. Thomas Hospital use silk while still others use silk worm gut.

In operating for appendicitis Prof. Morris of Middlesex Hospital sutures the peritoneum over the stump of the appendix after excision, while in the Royal College of Surgeons some of the operators apply carbolic acid instead of suturing. In mastoid operations the grafting process is successfully performed at St. Thomas Hospital and can be witnessed almost daily.

The amount of surgery done in London daily is immense and the student who has a ticket admitting him to several hospitals is often puzzled to make up his mind as to the best way to utilize his time to the greatest advantage.

After seeing the list of operations to be performed he has to select the ones he wishes to see and let the others go for that day, and in his eagerness to see work done by different men, he is likely to overwork himself unless he is very careful. Some of the large hospitals have, on an average, about one dozen operations daily, and quite a number of these institutions are modern and up to date, being well provided with fine operating amphitheaters and with all the appliances necessary for doing aseptic surgery, among which may be mentioned St. Bartholomew, St. Thomas University College and some others.

When a foreign student enters Germany for the purpose of post graduate study, his best way is to call upon the most noted medical and surgical men in the universities and they will take his address and send him invitations to their clinics where they will treat him cordially.

After matriculating and entering upon a course of work he will be impressed with the thoroughness and system with which the work is done. The German mind here, as in everything else, seeks to know the cause of all phenomena with which it comes in contact.

They are a people that are eminently suited to deep research in medicine and surgery, as well as any other line of work that requires untiring and protracted labor and toil, so it is no matter of astonishment that we find here so many deep investigators in professional work.

The German Government recognizing the good to the state by encouraging original research provides for this by appropriating money for this purpose. When a professor is once appointed for this line or work he has an enviable position indeed, and some of them live in royal style having fine palaces and surrounded by all the comforts of life. He is highly esteemed and honored by his countrymen and this is an incentive to others to improve their time and prepare themselves for similar honors. Thus the German's ambition is to thoroughly prepare himself for his work and to be held in high esteem by his people and not so much for the purpose of wealth; this certainly is to be commended, and would be fortunate for our noble profession if it obtained everywhere.

The average German has too much self pride to ask for charity, consequently there is not so much free treatment in the hospitals as in some other countries; he also prides himself in keeping his body, clothing and living apartments clean.

I was told in Berlin that I might meet poor people there as elsewhere, but I would always find them a clean, happy and contented people, and I found this to be true.

It is in the field of bacteriology that Germany has made the greatest advance and has gone deeper into the subject of pathology and clinical bacteriology than any other nation of people. I was told in a large pathological laboratory in Berlin by one of its teachers that we could not expect to have made much of a record in this line of work in our country, as we were too young as a nation and of course this is true, but I earnestly hope to see the day in the not distant future that our national congress will see the necessity of aiding our noble profession in like manner as does the German Government.

Some of the most eminent men in gynaecology operate entirely different from each other. For instance, Professor Landaugh performs vaginal hysterectomy by the clamp method for controlling hemorrhage and when he has finished an operation he will have a large handful of clamps hanging out of the pelvic canal. Profs. Olshausen and Duhrsen do away with the clamps and ligate each step of the operation, finally closing the vault of the vagina by suturing. The latter method would seem to be the better of the two, as the danger from infection would seem to be less than it would be to leave the vaginal vault open containing a handful of clamps. However, Prof. Landaugh claims for his method as good percent of recoveries as do the operators by the other method, thus proving that either method is successful in competent hands.

Speaking from a scientific standpoint the surgery done in Berlin is excellent yet one often sees surgical work done in the large clinics by a few operators that seems to be heartless if not brutal, and the fortitude and patience with which the inmates bear it is something to be wondered at. For instance, one will often see an abscess of the superior maxillary antrum opened and an opening made by chisel and forceps as large as a half inch in diameter into the cavity of the bone requiring several minutes to complete the operation and causing excruciating pain, yet all this would be borne without an anesthetic, and a great many other operations equally as painful are daily witnessed.

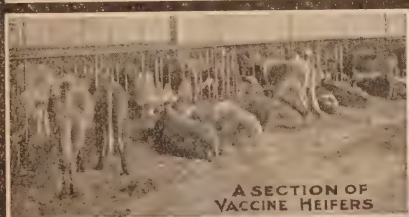
The only reason I can give for the tolerance of so much pain by these people is the high esteem in which the profession is held in Germany and that its opinion is respected.

Medical and surgical science here is built upon a true basis and everything is done radically according to scientific methods but my impression is that the profession does not use merely so much medicine as is habitually done in America.

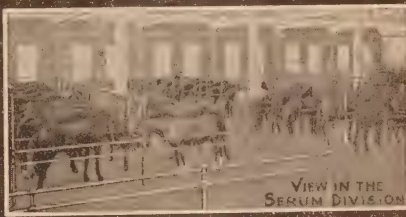
In conclusion I would say that while an American student can gather many useful things from the profession on the other side of the Atlantic, at the same I am confident that were some of the profession in Europe to come to our shores to learn our methods, they would return home much benefited.

WHERE PARKE, DAVIS & CO'S SERUMS AND VACCINES ARE MADE

THE TWIN STABLES OF THE BIOLOGICAL DEPARTMENT.



A SECTION OF
VACCINE HEIFERS



VIEW IN THE
SERUM DIVISION



NEW
RESEARCH
LABORATORY.



[Our nearly completed Research Laboratory, the new home of our Biological Department, represents a \$160,000 contribution to science. It is the largest and will be the most perfectly appointed laboratory building in the United States devoted exclusively to scientific investigation. At a cost of more than \$25,000 our Biological Stables have been enlarged, remodelled and equipped throughout with the most modern appliances. Perfect drainage, ventilation and lighting have been provided; scientific methods of drenching, cleansing and disinfection adopted; every detail requisite to rigid asepsis and antiseptics carefully planned and executed—all with an eye single to the safety and purity of our serums and vaccines.]

PREFERRED BY PHYSICIANS.

We are by far the largest producers of *Antidiphtheritic Serum and Vaccine Virus* in the world.

The unquestioned purity and potency of these products of our laboratories have made them the preferred Serum and Vaccine of the medical profession.

Antidiphtheritic Serum—Hermetically sealed glass bulbs.

Aseptic Vaccine—Glycerinated, cases of 10 tubes and 3 tubes, with rubber bulb.

Points, boxes of 10, each in an impervious envelope.

Always specify *Parke, Davis & Co.* when ordering.

LABORATORIES:
Detroit, Michigan, U.S.A.
Walkerville, Ont., Canada.
Hounslow, England.

PARKE, DAVIS & CO.

BRANCH HOUSES:
New York, Kansas City, Baltimore,
New Orleans, Chicago;
London, Montreal, Sydney (N.S.W.)

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, N. Y., Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S.	Ohio.	R. B. DONALDSON, D. D. S.	D. C.
E. PARMLY BROWN, D. D. S.	N. Y.	H. A. PARR, D. D. S.	N. Y.
A. L. NORTROP, D. D. S.	N. Y.	J. EMORY SCOTT, D. D. S.	Md.
E. L. HUNTER, D. D. S.	N. C.	C. L. ALEXANDER, D. D. S.	N. C.
W. W. WALKER, D. D. S.	N. Y.	M. M. MAINE, D. D. S.	Conn.
OSCAR ADELBURG, D. D. S.	N. J.	J. W. DAVID, D. D. S.	Texas.
G. MARSHALL SMITH, D. D. S.	Md.	A. C. BREWER, D. D. S.	Md.
C. M. GINGRICH, D. D. S., Resident.	Md.	J. ROACH, D. D. S.	Md.
J. HALL MOORE, D. D. S.	Va.		

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

W. W. DUNBRACCO, D. D. S.	J. K. BURGESS, D. D. S.	J. C. SUTHERLAND, D. D. S.
GEO. V. MILHOLLAND, D. D. S.	CHAS. THEBERATH, D. D. S.	
L. M. PARSONS, D. D. S.	HARRY E. KELSEY, D. D. S.	C. H. CARSON, D. D. S.
H. M. LEVER, D. D. S.	C. S. GORE, D. D. S.	L. F. PALMER, D. D. S.
C. R. STEWART, D. D. S.	L. D. CORIELL, D. D. S.	
H. H. HAYDEN, M. D., Demonstrator of Anatomy.		
C. F. BLAKE, M. D., Demonstrator of Anatomy.		

The Sixty-Third Annual Session will commence on the 1st of October, 1902, and continue until May, 1903.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.

THE NAME MULFORD

on a package of Vaccine, Antitoxin
or a Pharmaceutical is a guarantee of

PURITY, EXCELLENCE
AND STRENGTH



Valuable and Interesting Literature, with new Price-List,
mailed for the asking

H. K. MULFORD COMPANY, Chemists
PHILADELPHIA NEW YORK CHICAGO

College of Physicians and Surgeons OF BALTIMORE.

—♦♦♦ FACULTY ♦♦♦—

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- AARON FRIEDENWALD, M. D.,
Professor of Diseases of the Eye and Ear.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Medical Jurisprudence and Director of Pasteur Institute.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, A. B., M. D.,
Professor of Obstetrics.
- WM. ROYAL STOKES, M. D.,
Professor of Pathology and Bacteriology.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- C. HAMPSON JONES, M.B., C.M. (EDIN.) M. D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- HARRY FRIEDENWALD, A. B., M. D.,
Associate Professor of Diseases of the Eye and Ear.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MCLEARY, M. D.,
Associate Professor of Histology and Pathology.
- CHARLES E. BRACK, M. D.,
Associate Professor of Obstetrics.
- JOHN RUHRÄH, M. D.,
Clinical Professor of Diseases of Children.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Clinical Professor of Diseases of the Rectum.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MOGLANNAN, M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- MELVIN ROSENTHAL, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- ALBERTUS COTTON, M. D.,
Associate Professor of Orthopedic Surgery.
- ARCHIBALD C. HARRISON, M. D.,
Demonstrator of Anatomy.
- GLENN M. LITSINGER, M. D.,
Demonstrator of Obstetrics.
- A. SAMUELS, M. D.,
Demonstrator of Chemistry.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- JOHN MASON KNOX, JR., M. D.,
Demonstrator of Pathology and Physical Diagnosis.
- CHARLES B. CANBY, M. D.,
Demonstrator of Pathology.
- OTTO C. GLASER, A. B.,
Demonstrator of Embryology.
- L. H. HIRSBERG, A. B., M. D.,
Demonstrator of Bacteriology and Assistant in Neurology.
- C. W. G. ROHRER, M. D.,
Demonstrator of Pathology and Resident Pathologist.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Assistant in Genito-Urinary Surgery.
- OTTO SCHAEFER, M. D.,
Assistant in Eye and Ear Diseases.
- HERMAN WESTPHAL, M. D.,
Assistant in Surgery.
- W. EDWARD MAGRUDER, M. D.,
Assistant in Diseases of Children.
- L. J. ROSENTHAL, M. D.,
Assistant in Diseases of Stomach.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Table of Contents Page III.

Issued Quarterly

Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS
BALTIMORE.

Vol. V

No. 4

JANUARY, 1903

PUBLISHED AT
Baltimore and Eutaw Sts. Baltimore, Md.

ANNOUNCEMENT
OF
POST-GRADUATE COURSES
FOR
PRACTITIONERS OF MEDICINE

Beginning May 1st, 1903, and continuing for six weeks. These embrace courses in *Medicine* (including daily visits to the medical wards), *Pediatrics* and *Nervous Diseases*, *Surgery* (general, orthopedic, genito-urinary surgery and cystoscopy), *Gynecology*, *Operative Obstetrics*, *Ophthalmology* (including a course in the use of the Ophthalmoscope), *Otology*, *Laryngology*, *Pathology* (Demonstrations of fresh specimens and microscopic course), *Bacteriology* and *Clinical Laboratory* courses in the microscopic and chemical examination of the blood, urine, gastric juice, feces, etc., etc.

These courses *are entirely practical*.

A certificate of attendance will be given at the end of the course.

For schedule and further information apply to

DR. HARRY FRIEDENWALD, CHAIRMAN,

College of Physicians and Surgeons,

BALTIMORE, MD.

The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,
CATONSVILLE, MD.

REFERENCES:

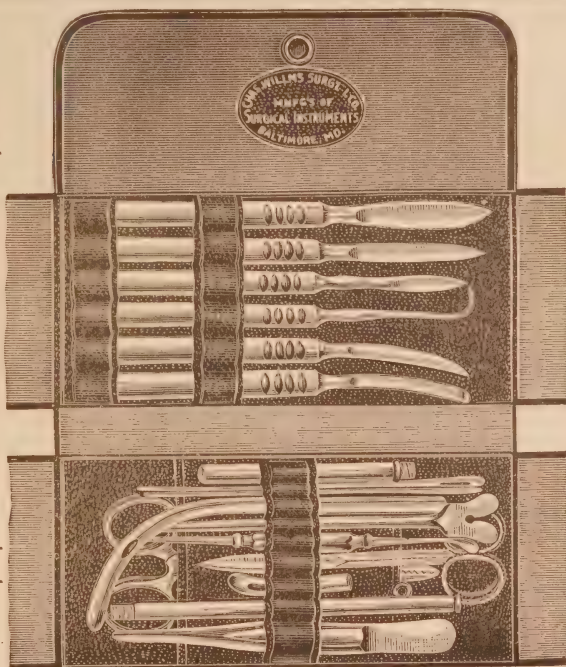
Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
The Friedenwald Memorial Meeting.—Dr. Friedenwald as Man, Friend and Colleague.	
DR. W. SIMON,	97
Dr. Friedenwald as Teacher, Scientist and Physician. DR. JOHN RUHRÄH,	102
By DR. JOHN D. BLAKE,	106
The Puerperium. (Concluded from No. 3.) DR. ALFRED H. QUESSY and DR. CHARLES F. MERRILL,	107
Stricture of the Esophagus. DR. WM. A. McMILLAN,	115
Editorial,	121
Personal Notes,	iv, 123
Correspondence,	125

**"OUR
LEADER."**

Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.



All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,
MANUFACTURERS AND IMPORTERS,
300 N. HOWARD STREET, - - - BALTIMORE, MD.
 PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES.

CLINICAL LABORATORY OF Dr. CHARLES E. SIMON.

Private instruction in Clinical Chemistry and Microscopy; in Normal and Pathological Histology. Facilities for original work.

Examinations of blood, urine, stomach contents, feces, tumor specimens, etc.

Chemical and bacteriological examination of drinking water, milk, etc.

1302 MADISON AVE., BALTIMORE, MD.

Personal Notes.

DR. J. H. HAIZLIP, '97, is located at White Cliffs, Ark.

DR. G. KIRBY COLLINS, '00, of Wilmington, N. C., was about the College in September for a few days.

DR. HUSTON SPYKER, '02, was married to Miss Ethel Rockhill, of Lima, Ohio, Wednesday, October 29, 1902.

DR. D. M. HESS, '02, has purchased the practice of DR. H. B. BRUNER, '95, at Summerhill, Cambria county, Pa.

DR. A. A. SWAYZE, '97, of Hackensack, N. J., was married, Oct. 17, '02, to Miss Annie Sheppard, of West View, N. J.

DR. FRANCIS J. SNYDER, '87, has returned from his western trip and opened an office at 409 South George St., York, Pa.

DOES EVERYTHING

that *syrups* of hypophosphites do, that is beneficial.

DOES NOTHING

that *syrups* of hypophosphites do, that is detrimental.

AROMATIC SOLUTION OF HYPOPHOSPHITES.

Manufactured by
HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

Pint samples furnished upon application.

LAPACTIC PILLS

R

Aloin, S. & D.	gr. $\frac{1}{4}$
Strychninae,	gr. $\frac{1}{80}$
Extr. Belladonnae,	gr. $\frac{1}{8}$
Ipecacuanhae,	gr. $\frac{1}{16}$

M: et ft. Pil. No. 1.

The best and most reliable laxative pill ever offered the profession. The formula and name were originated by us, and because of the freedom of our Aloin from any resin of aloes or resinified aloes, due to our manufacturing it ourselves, Lapactic Pills never gripe and never fail. This cannot be said of the many substitutes offered the profession and the trade. Hence, please specify on your prescriptions and orders

SHARP & DOHME

CHICAGO.

BALTIMORE.

NEW YORK.

NEW ORLEANS.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap has been used exclusively in this baby's bath from birth, and her perfect skin and luxuriant hair excite wonderful interest and admiration.

AS A NUTRIENT SOAP
FOR THE SKIN . . .

Resinol Soap

IS WITHOUT A
. . . . PARALLEL.

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.,
SYDNEY, N. S. W.
Agents for Australasia.



A Friedewald

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE FRIEDENWALD MEMORIAL MEETING.

DR. FRIEDENWALD AS MAN, FRIEND AND COLLEAGUE.

BY DR. W. SIMON.

A few miles to the north of the home of my childhood, the old university town of Giessen, Germany, extends a charming valley, covered with a carpet of green meadows and flanked by rows of undulating hills.

The ruins of an old castle look down upon the few hamlets which nestle in this delightful vale, and from one of these villages emigrated, in the year 1832, Jonas Friedenwald, seeking his fortune in the new world.

Landing in Baltimore, he made this city his permanent home and soon became prominent as a successful business man, a respected citizen and a widely known philanthropist.

Among the four children born to Mr. Jonas Friedenwald, Aaron was the youngest. He was ushered into this world on the 20th of December, 1836, and grew up under most favorable home influences.

After having received his early education in the schools of Baltimore, he took up the study of medicine by becoming a student in the office of the late Professor Nathan R. Smith, and matriculating at the University of Maryland, from which institution he graduated in 1860.

The next two years were spent abroad in the pursuit of medical education. The hospitals in Vienna, Prague and Paris were visited, and a considerable time was devoted to the study of the diseases of the eye under the guidance of the famous Dr. von Graefe in Berlin, who, at that time, as perhaps the most skillful oculist in the world.

Returning to Baltimore in 1862, Dr. Friedenwald at once began to practice general medicine, making, however, a specialty of the diseases of the eye and ear.

What Dr. Friedenwald has accomplished in those 40 years, so rich in labor and in fruitful results, may best be shown by considering him separately as physician, scientist and teacher. This will be done by Dr. Ruhräh, who, as a former pupil of our departed friend, had ample opportunities to judge his value and influence in those directions.

As to myself, I have been requested to speak of Professor Friedenwald as man, as citizen, and as a member of our Faculty.

Indeed, he was a man; a man in the fullest, the best, the noblest meaning of the word. To be a man in this sense means to have strength, will-power, energy, endurance. And of all these Dr. Friedenwald not only possessed a full share, but he applied them in the right direction; i. e., he was guided by a clear conception, a critical judgment and by great executive ability.

That a man with such a strong personality should make his presence felt in whatever circle of people he would appear is but natural. Whenever he participated in meetings of a public character he quickly became one of the leaders. The fact that he was chosen as an executive or presiding officer of scientific, educational, benevolent, religious and even political gatherings, fully demonstrates that the value of the man, as a man, was fully recognized by others.

But it also shows that Dr. Friedenwald was not one-sided and that, while his calling was that of the physician, his activity and his influence extended in many other directions.

Indeed, he was most decidedly a public spirited man, and devoted much of his time to duties which his connection with various educational, charitable and religious institutions imposed upon him.

He took a deep interest in general and local politics, had well defined opinions regarding them, and was deeply interested in the reforms of

our government, recognizing the many forms of corruption that abound in it. But at the same time he was imbued with intensely optimistic views concerning our republic and its form of government, and was ever a patriotic American to the backbone.

In his relations with people, Dr. Friedenwald was thoroughly democratic. He received the rich and the poor with equal friendliness, and in his dealings with men he was as considerate of the feelings of those in rags as of those upon whom fortune had smiled.

He was always able to find reasons and extenuating circumstances to account for the weaknesses and wrongdoings of the unfortunate, and was ever ready to champion their cause, but he was less willing to forgive the meannesses and conceit of some of the wealthy.

While it does not fall to me to speak of our friend as a physician, I should at least emphasize the fact that he never lost himself as a *man* in the *physician*, and throughout his long professional career, at all times, had a large clientele of the very poor, for he was never willing, even in his busiest days, to turn them aside.

The relation between him and a large number of his patients was not that of physician and patient alone, but that of intimate friends, and many were wont to consult him in all their troubles.

It is but natural that a man whose whole nature made him the friend of the poor and helpless should possess in a large measure those qualities which, under proper conditions, are the very foundation of true happiness, i. e., fondness and love for home and home ties.

Many of those who came in almost daily contact with the Doctor outside of his home, scarcely knew how deep his affections were for those near him.

From the days of childhood an intimacy had sprung up between him and his parents, and continued during a lifetime, such as is but rarely witnessed.

This remarkable devotion and affection which he evinced at all times for his father and mother are well shown in letters written to them from Europe during the years 1860 to '62. In these letters, which are preserved as a highly treasured heirloom, are found many touches which are truly poetical and show that as a man of 25 he still felt, and was not ashamed to express, a childlike love for his mother. This intimate

relation continued for life, and there was for all the many years scarcely a day that he did not visit his parents until they closed their eyes forever.

With his marriage to Miss Bertha Bamberger in June, 1863, Dr. Friedenwald laid the foundation for most happy domestic relations; a complete and perfect understanding existed at all times between husband and wife; the joys, the sorrows and the interests of the one were those of the other. No step was taken, nothing was ever done, be it great or small, but that it was first discussed between them, and it was through the help of his wife that the Doctor was able to carry out the great amount of work which he accomplished.

As a father he was strict but exceedingly kind, and fond of having his children with him. Their moral and intellectual education was at all times uppermost in his mind, and neither time nor money was spared when the welfare of the children was concerned. When illness came he acted not only as physician but as nurse as well.

We all can realize with what eminent satisfaction the father must have watched the development of his children, how proud he must have felt in seeing his noble sons climb higher and higher on the ladder leading from success to success. But of this he would not speak, except to her who shared his innermost thoughts.

The family ties were not confined to the household alone; there was not a relative, no matter how distant, and especially the less fortunate ones, who did not feel deep attachment for him, and who were not under obligations to him for friendly assistance and wise counsel in times of sorrow and trouble.

Those who met Dr. Friedenwald for the first time, or who had but a superficial acquaintance with him, were under the impression that he was an exceedingly polite and polished gentleman, but rather stern and austere than otherwise.

This latter impression soon vanished on closer acquaintance, because, in reality, he possessed a never-failing fountain of wit and humor, and highly enjoyed telling, or listening to, a good story. It was this faculty of readily detecting the humorous side of a situation which made him an excellent after-dinner speaker. Indeed, whenever he was found on the list of those who had to respond to a toast, the assembled guests

knew beforehand that a treat was in store for them, and never did they leave disappointed.

Dr. Friedenwald was decidedly progressive; he not only would willingly accept modern views and modern methods, but in many instances would act as the leader in modernizing existing conditions.

There was, however, one field in which change or progress to him was inadmissible. I refer to his religious convictions, which were unalterably those of his fathers. As a descendant of the Jewish faith, he faithfully adhered to the doctrines of his church.

How highly he was cherished by those to whom he was united in religious bonds was touchingly demonstrated at the memorial services held in his honor at the McCulloh Street Synagogue on November 9.

Many distinguished representatives of the Jewish faith had there gathered from near and far to pay tribute to the memory of their departed friend; and I cannot do better than to repeat here a few of the beautiful words spoken by Dr. Mendes, of New York, the President of the Orthodox Hebrew Congregations of America. In the course of his oration, Dr. Mendes said:

“So modest a man would not have his praises rehearsed anywhere; so reverent a man would not have them rehearsed in the house of God. I take it you are animated with the same motives which have brought me here—not to speak in the praise of Dr. Friedenwald, but we are here because we loved him. He was such a lovable man that we are impelled to come here to-day to do honor to his memory. We loved him for his modesty; we loved him for his reverence, and we loved him for his loyalty to the faith of his fathers.”

And now, before closing my remarks, I have yet to say a few words of Professor Friedenwald as a member of the Faculty of the C. P. S.

He was elected to the chair of diseases of the eye and ear in 1873, but shortly after the founding of our institution. This position he filled with eminent satisfaction to all concerned until the day he was taken from us on August 26, of this year.

During the greater part of these many years it has been my good fortune to be associated with him in our Faculty, and it was through this relationship as colleague that the bonds of friendship were established between us.

I first learned to respect him for his earnestness, fairness and conscientiousness which he brought to bear upon every important question under consideration; I then learned to admire him for the sake of his strong character, his wisdom and farsightedness; and I finally learned to love him for the sake of his integrity and charity which he so freely dispensed with words and deeds.

His love for the welfare of our College was unbounded and he was ever ready to make sacrifices for its sake.

While Professor Friedenwald, during these 30 years of faithful service, has done much for our school as an able teacher, I am inclined to think that even more valuable to our institution were the services rendered by him through his clear judgment, his business tact, his progressive and yet conservative views, his impartial decisions, his executive ability, and, in fact, through his thoroughly noble example.

In him the city has lost a good citizen, the profession an able representative, the poor an adviser and helper in need, and we, as a Faculty, have lost in him a strong co-worker, a wise counsellor and a dear friend.

DR. FRIEDENWALD AS TEACHER, SCIENTIST AND PHYSICIAN.

By DR. JOHN RUHRÄH, '94.

Since the time when Dr. Friedenwald began to teach, several thousand men have listened to his lectures. Of these, many like the Doctor have passed into the great beyond, some have ceased from the practice of their profession, but still, over two thousand remain, forming the active Alumni Association of the College of Physicians and Surgeons.

It is in behalf of these, his students, that I wish to pay a tribute to his memory. Such events as this remind us of "the inaudible and noiseless foot of time." The Psalmist has truly said that we spend our years as a tale that is told, and, now, that one of the Faculty of our Alma Mater has written finis to his life's story, we, his students, wish to express our admiration for him as a teacher, as a scientist, as a physician, as well as for his sterling manhood of which Dr. Simon has so eloquently spoken.

Most of you already know the facts about his life. I need hardly recount them here. He left school at the age of fourteen to enter his brother's factory in a clerical capacity. His collegiate course was taken in casting up accounts and following the details of the business. The young clerk was not idle during his spare time, but studied and read assiduously, mastering the elements of the sciences and delving into the literatures of this and other countries.

At twenty-one he announced his intention of studying medicine and no amount of persuasion could make him desist from the ideal which he had set for himself. His mother told him that he would not be able to make the salt of his bread practicing medicine, and we are glad in this instance that the parental prophecy did not come true.

After two years of study in the office of Dr. Nathan R. Smith and of lectures in the University of Maryland he sailed for Europe, where he spent two years and a half in the Universities of Berlin, Prague, Vienna and Paris. In looking over his lecture schedules which his widow has carefully preserved we see the names of such men as Virchow, von Graefe, von Langenbeck, Frerichs, Traube, Hebra, Oppolzer, Arlt, Skoda, Rokitansky, Desmares and Tarnier.

What a glorious opportunity it was to have listened to those Masters of Medicine! That he recognized his privilege, at that time, is proven by the following extract from a letter written to the Maryland and Virginia Medical Journal, in January, 1861.

He wrote, "I have found that the medical luminaries here are zealously devoted to the cultivation of the science, on the basis which distinguishes medicine of the present day from that of former times. In regarding nothing as reliable which does not emanate from ample observation, scientific research and rational deductions, they have been able to free it from many of the false notions which had gained a stronghold by tradition, and to contribute a great deal of valuable material to its reconstruction."

It was from the immortal von Graefe that he received his first lessons in the diseases of the eye. Just at this time the new operation for glaucoma was the talk of the medical world and the description given by the enthusiastic young student in his letter to the above mentioned journal was among the first, if not the very first, that we have in the medical literature of this country.

When he returned from Europe he started in the practice of his profession, but he did not let it absorb all of his time. He kept abreast of all that was new and interesting both in scientific and literary fields. He was an accomplished linguist, thoroughly at home in English, German and Hebrew and with a good knowledge of French and Latin. Besides knowing the languages themselves he knew their literatures. He was also what is rare among physicians, a good mathematician.

He was a specialist who had been trained first for the practice of medicine and then for his specialty. One thing he kept constantly before his mind, and that was the relation of ocular diseases to general medicine. His most important contributions were along this line. Read his articles on "Optic Neuritis," on "Optic Nerve Atrophy," on "Ocular Paralysis," on "Uraemic Amaurosis," and, perhaps better than all, on "The Relation of the Eye to Spinal Diseases."

A very important literary contribution was "The History of Jewish Physicians," published in 1897 by the Gratz College of Philadelphia.

He took an active part in the professional life of the city. He was a member of the Medical and Chirurgical Faculty and for twenty-five years was always a member of some important committee. In 1890 he was elected President of that society. It is interesting to note that the opposing candidate at his election was Dr. William T. Howard, who was elected President this year. Dr. Friedenwald was among the most active of the members who secured for the library of the above society the new house up town.

He was also one of the founders of the Maryland Ophthalmological Society and was its first president.

His most important public work you are all familiar with. He suggested the idea of calling a meeting of the representatives of the medical colleges of this city to consider the betterment of the medical schools. He was chairman of this convention and suggested that they send out a call to all the medical colleges of the United States. It was in this way that the American Association of Medical Colleges was formed. He was elected its first Vice-President, Dr. Davis, of Chicago, having been elected President.

He was visiting ophthalmologist to the City Hospital, to the Hebrew Hospital and to the Nursery and Child's Hospital. During the latter

part of his life he devoted a great deal of his time to the Baron Hirsch Fund.

As a practicing physician he was more than successful. He not only won his patients' confidence and respect but their love as well. One of them said to me a few days ago that when he entered the house they all felt that there was no longer cause for alarm, that they trusted absolutely to his skill and judgment. She added that she did not think that they could ever get the same amount of confidence in any other physician. This is how all his patients regarded him.

From 1873 he was Professor of Diseases of the Eye and Ear in the College of Physicians and Surgeons and he served in this capacity twenty-nine years.

In his teaching he was always interesting, up-to-date and enthusiastic. As he grew older his interest did not flag and there was no change in the tone and vigor of his lectures. He was always ready for a joke or a good story to enliven his class and there existed between teacher and student a very pleasant good fellowship. He was preeminently the students' friend and they recognized him as such and many a one sought his kindly advice and good counsel.

It is not so much, however, of his teaching of ophthalmology that I wish to speak. A professor teaches more than mere science. The daily contact with one whose thoughts and deeds are of the noblest kind is an example and a power for good. The students of such a man must inevitably feel and imitate his ways. And so it is that we have learned a double lesson from Professor Friedenwald. As a teacher of his sciences he was both instructive and inspiring, while as a man we might say in the words of King David, that in him mercy and truth are met together; righteousness and peace have kissed each other.

I think this silent influence which he spread about him was indeed his most precious gift as a teacher. This influence happily will live, for he was one of those men who, as Dr. Osler has said, "remind us continually that in the records of no other profession is there to be found so large a number of men who have combined intellectual prominence with nobility of character. The higher education so much needed to-day is not given in the school, is not to be sought in the market place, but it is to be wrought out in each one of us for himself; it is

the silent influence of character on character and is in no way more potently felt than in the contemplation of the lives of the great and good of the past, in no way more than in the 'touch divine of noble nature gone.'"

One thing above all could and did the student learn in his dealings with Dr. Friedenwald. One thing above all has left its imprint where he worked. This was that he always did what he thought to be his duty and to be right. Not because it was the best policy, not because it was expedient, but because it was right. And hand in hand went a second trait presupposed by the first. He was most precise in promise keeping.

There is no need to say more, no need to try to express the regret and sorrow that we all feel. We would say of him as David said of Abner, "There is a prince and a great man fallen this day in Israel."

DR. JOHN D. BLAKE.

Mr. Chairman:—I would do violence to the promptings of my heart, did I not voice the sentiments that now animate my breast and lay my humble tribute of respect upon the bier of our departed friend.

With the exception of a few members of the Faculty, and the members of his own family, I expect I knew Professor Friedenwald longer and more intimately than any of those present to-night.

My knowledge of him goes back to 1873, when he entered upon his duties at this College, he and the late Professor Thomas R. Brown having been elected at the same time in that year to fill the vacancy caused by the death of Professor George L. Robertson.

For several years after my graduation, in 1875, I was his assistant, which brought me in close and daily contact with him. From 1873 to the day of his death I never found him other than the same congenial, approachable and lovable man; devoted to duty, he was always found treading its path as he saw it lying outstretched before him. Whether it be canopied by clouds or sunbeams, whether the sun shone or the storm raged, indifferent to all that assailed or allured, heedless alike to the trumpet's notes or the siren's voice, I say he trod the path of duty with a brave heart and a hopeful spirit, fearing God, but fearless of man.

He was a man that only permitted the difficulties of the situation, if there were any, to serve to call out his manhood and develop his resources. Confiding as he always did in that mental and physical strength with which Heaven had blessed him, and sustained by the fervor and force of his own conviction as to his duty in the premises, he was always in a position to be neither elevated by the hope of success nor depressed by the fear of failure.

In the death of Professor Friedenwald I have lost a wise counsellor, a true and tried friend, a friend that I loved.

THE PUERPERIUM.

BY DR. ALFRED H. QUESSY, '02, AND DR. CHARLES F. MERRILL, '02.

(Concluded from No. 3.)

Influence of Suspended Lactation on the Puerperium.—According to the histories, the breasts were dried up in 5 cases, one of which had an abnormal puerperium. The breasts were not dried up in 142 cases, 35 of which, or 24.7 per cent, had abnormal puerperia. In one case no note was found regarding this point. These figures can hardly be depended upon, as the number of children disposed of was quite in excess of that given as the frequency of dried up breasts, and thus no conclusions can be drawn.

Influence of Lacerations on the Puerperium.—We have considered as slight any laceration in which no sutures or not more than 4 were used. Anything beyond this, but not into the rectum, as a medium laceration; and into the rectum, as an extensive or complete laceration. In some medium lacerations, for instance, to the rectum, only 4 sutures were used, but notwithstanding this fact, we considered it a medium laceration.

Lacerations occurred in 67 of the 150 cases as follows: 50 slight, 13 of which, or 26 per cent, had abnormal puerperia; 16 were medium, 6 of which, or 37.5 per cent, had abnormal puerperia; 1 was extensive, the tear extending into the rectum, in which case an abnormal puerperium occurred, said to be due to constipation. Episiotomy was done in this case.

Conclusions.—Of course lacerations may be the means of causing an abnormal puerperium, and in all probability statistics usually show that the liability to an abnormal puerperium increases the more extensive the laceration. We find this to be the case here, the frequency of abnormal puerperia increasing with the extent of the tear. Our figures are not intended to mean that lacerations were *the* cause in producing an abnormal temperature, but simply that abnormal puerperia occurred, be it incidentally or not, in direct ratio to the extent of the tear.

II. PRIMARY RISE.

By this is meant a rise of temperature over 100.4, occurring within the first 24 hours after labor, and lasting usually not more than 24 hours. The importance of it is to know that it may occur, and that it is of no especial importance from a prognostic standpoint. It occurred in 13 of our 150 cases, or 8.7 per cent. The highest was 103.6, pulse 128; the lowest 100.5, pulse 66. The exact cause of a rise of temperature of this kind does not seem to be well understood.

It is said that a long 2d stage has an influence on the occurrence of a primary rise, in that a primary rise very frequently follows. On the strength of this we may say that anything during labor which tends to exhaust the patient, which exhaustion is preceded by a more or less excessive amount of exertion on her part, may act causatively, at least in part.

Following out this line of theorizing, we have reviewed the cases with the above points in mind, as well as from the standpoint of manner of labor, viz.: spontaneous or instrumental, and of lacerations.

1. As to the influence of the duration of second stage on the primary rise, we find that, of the 75 cases, the duration of second stage of which was one hour or under, 3 cases, or 4 per cent, showed a primary rise; of the 46 cases each having the duration of 2d stage 2 hours or under, a primary rise occurred in 5 cases, or 10.9 per cent; of the 14 cases which each had a 2d stage of 3 hours or under, 2 cases, or 14.3 per cent, had a primary rise; of the 6 cases of a 2d stage of 4 hours or under, only one, but 16.7 per cent, had a primary rise. There were no cases showing a duration of the 2d stage as being 5 hours or under,

or 6 or under. One case of the 2 which showed the duration as being 7 hours had a primary rise. In one case of an 8-hour 2d stage, no primary rise occurred. In 6 cases the duration of 2d stage was not given and consequently were not considered, but we might mention that a primary rise occurred in one of them.

It is seen from the above that there is a direct relation between the frequency of the occurrence of a primary rise and the duration of the 2d stage, in that as the length of the 2d stage increased, so did the frequency of primary rise. This is true in those cases up to the 8-hour case, which was normal. There being but one of these, it can be practically dropped out of consideration.

2. As to the influence of labor on the primary rise. A primary rise occurred in 8, or 5.9 per cent, of the 135 spontaneous cases. It occurred in 2, or 40 per cent, of the 5 high forceps cases. In the 8 low forceps cases it occurred once, or in 12.5 per cent. In each of the single cases of medium and combined high and low forceps, a primary rise occurred.

From all this we see the spontaneous cases showing a much smaller percentage of primary rises, and the ratio of those which occurred in operative cases increasing with the severer operations.

The fact that one of the spontaneous cases, in which a primary rise occurred, was one of premature labor, the foetus being dead, is interesting to note as a possible contributing factor in that particular case; as also is the fact that there was a flat rachitic pelvis in one of the cases in which high forceps were used, and which was one of the two in which a primary rise occurred, for the same reason.

Thus the results obtained under these 2 heads, viz., duration of 2d stage, and spontaneous or instrumental labor, go to show, as far as possible, that the theory presented above is, at least to a great extent, correct.

3. As to the influence of lacerations on the primary rise. A primary rise occurred in 8, or 16 per cent, of the 50 cases which had lacerations termed slight. Among these was the combined high and low forceps case referred to above. Of the 16 cases having medium lacerations, 2, or 12.5 per cent, showed a primary rise. In the single case of extensive laceration into the rectum, and in which episiotomy was done, a primary rise was noted.

As is seen, primary rise was more frequent in slight lacerations, providing we leave out the one extensive laceration. The true cause for this is not known if lacerations alone, as the cause of the primary rise, are considered. If lacerations are productive of a primary rise, one might expect it to be more frequent in more extensive lacerations. This is true in the one case of complete laceration, the primary rise being 100 per cent. But conclusions cannot be drawn from only one case, and the fact remains that primary rises were more frequent in slight lacerations.

III. PYREXIA.¹

It is any rise of temperature over 100.4 during the puerperium, occurring after the first 24 hours, and with or without a primary rise. This temperature must have some cause, and the causes assigned to the various cases are 4 in number: bowels, breasts, intercurrent diseases, and puerperal infection. A large percentage of the cases do not come under these respective headings, and these are classed as cause unknown. There were 36 cases of pyrexia, 2 of which had more than one cause. The pyrexia in 4 cases was due to bowels; in 14 cases to breasts, in 3 cases to intercurrent diseases, and in 2 cases to puerperal infection. The cause in 15 cases was unknown. The highest temperature in any one case is that given for that case. It would be presumptuous on our part, to say the least, to even intimate that the assigned cause in any given case was probably questionable; therefore in reviewing each case under its heading, it will be our aim merely to point out important factors which might call for consideration before the cause of any rise in temperature is decided upon.

1. Cases in which the temperature was said to be due to bowels. There were 4 such cases, 2 of which were given as probable, and one of these also had a probable cause, viz., caked breasts.

Case 1. Temperature between 103 and 104, was spontaneous, examined by 2 persons, had a 2d stage of 2 hours' duration, normal lactation, a slight tear, and the pelvic organs on discharge were normal.

¹ It is only right to mention at this point that it has not been practical at the Maryland Lying-In Asylum to make bacteriological examinations of the uterine lochia in cases in which an elevation of temperature occurred. The authors are perfectly aware of the fact that accurate statements as to the cause of a given rise cannot be made without this aid; nevertheless, we thought it would be of interest to analyze our cases even with this important omission.

(This case shows the manner in which we have analyzed the cases, and in the following cases only those points which might have some bearing on what we desire to show will be mentioned. The cases have been further classified according to the temperature, as follows: from 100.4 to 101, 101 to 102, 102 to 103, etc.)

Case 2. Temperature between 100.4 and 101, high forceps were used, 3 persons examined, duration of 2d stage was 6 hours, and the laceration was extensive, *i. e.* into the rectum.

Case 3. A probable case, temperature between 100.4 and 101; cause tympanites; caked breasts, which were given also as a probable cause, and a slight tear.

Case 4. A probable case, temperature between 101 and 102, and a medium laceration. Nothing else of any importance.

There was nothing of particular interest in Case 1, but in Case 2 the long 2d stage, the high forceps, and particularly the extensive laceration are points worthy of notice. Case 3, in which tympanites and also probably caked breasts were given as causes, is of interest probably since it helps to show that either more than one factor is operative in some cases or that it is very often difficult to say to what the temperature is due.

2. Cases in which the temperature was said to be due to breasts. There were 14 such cases, 2 of which were probable, and one of the probable is the same as Case 3 mentioned above, so will be left out of consideration here.

Cases 7, with a temperature between 100.4 and 101, 5 and 18, both having a temperature between 101 and 102, and 12, with a temperature between 102 and 103, show nothing except that Cases 7, 5 and 12 were each examined by 3 persons, Case 18 by 4 persons, and in the latter case no note was found under lactation.

Case 6, with a temperature between 102 and 103, was examined by 3 persons and sustained a medium laceration.

Cases 8, 10 and 15, all having a temperature between 100.4 and 101, were examined by 3 persons, and had slight tears.

Of the 3 remaining cases, having a temperature between 100.4 and 101; Case 13 was examined by 4 persons, had a 3-hour 2d stage, and

sustained a slight laceration; Case 14 was examined by 5 persons and sustained a slight tear; and Case 16 had a slight laceration.

Cases 9 and 11, having a temperature between 101 and 102, were each examined by 3 persons, both had slight tears, and in Case 11 the condition of lactation was in question.

The only remaining case, No. 17, was said to be probably due to engorgement; 4 persons examined this case and for some reason no note was made of organs on discharge, with the exception of the perineum, which was normal.

In all of these cases, the cause breasts means caking, with the exception of the probable case of engorgement.

Case 9 had 2 rises of temperature, the first being due to caking and the second to cause unknown, and will be referred to again.

The special points worthy of notice in these cases seem to be the number of persons examining in some of the cases, the 3-hour 2d stage in one, the medium laceration in one, and the slight tears in 8 cases.

3. Cases in which the temperature was said to be due to intercurrent diseases. There were 3 such cases, 2 having a temperature between 103 and 104, and one a temperature of 105.5.

Case 28, with temperature between 103 and 104, acute tonsilitis being given as cause, shows that 3 persons examined, and that slight caking occurred.

Case 33, temperature between 103 and 104, malaria being the cause, was examined by 4 persons, and had a medium laceration.

Case 34, temperature 105.5, malaria as cause, was examined by 3 persons, and sustained a slight laceration. Non-union occurred, caustic was applied, and a vaginal ulcer resulted. Spleen was slightly enlarged on discharge.

At first sight one might think that the slight caking in the tonsilitis case might have had something to do with the fever, but probably it would be more logical to consider it as being secondary to the condition due to the tonsilitis.

The medium laceration in one of the malaria cases is to be considered.

The non-union of the slight laceration in the other malaria case, we

think, ought to be considered from the standpoint of effect rather than of cause. We cannot say anything as to whether or not the malarial organisms were found.

4. Cases in which the temperature was said to be due to puerperal infection. Only 2 cases come under this heading.

Case 31 showed a temperature on the 3d day between 101 and 102. This was caused by a retained clot. Otherwise the case was a perfectly normal one.

Case 30, temperature between 103 and 104, was the only case in which septic infection was positively given as a cause of temperature. It was the emergency case we have already referred to, in which the child was born on the hospital stairs. The breasts caked at variable times. Whether or not this diagnosis was arrived at by a bacteriological examination we cannot say.

5. Cases in which the cause of the temperature was unknown. These cases were 15 in number, one of which is the same case as that which had a rise of temperature due to caking. The temperature due to cause unknown occurred much later in the puerperium than that said to be due to caking.

In 8 of the cases, 3 persons examined, divided as follows as to temperature: between 100.4 and 101 in 2 cases, between 101 and 102 in 3 cases, between 102 and 103 in 2 cases, and between 103 and 104 in 1 case.

Both of the cases with temperature between 100.4 and 101 had slight lacerations, as did also two of the 3 cases having a temperature between 101 and 102, the remaining case having a medium laceration.

Of the 2 cases having a temperature between 102 and 103, one had a medium laceration. One case was examined by 4 persons, had a 2d stage of 4 hours' duration, and a medium laceration; the temperature in this case was between 101 and 102.

One of the cases having a temperature between 101 and 102 was noted as having pulmonary tuberculosis on discharge.

From the mere fact that the causes in all these cases were unknown, and from what has just been given, it is evident that anything acting as a possible cause in any way is in the majority of cases difficult to discover.

With the exception of the 4 cases having slight lacerations, and the 3 having medium lacerations, one of which being examined by 4 persons and having a 4-hour 2d stage, and the case with the pulmonary tuberculosis on discharge, there is nothing especially to note.

As regards the number of days spent in bed and in the hospital respectively, of which nothing has as yet been said, the following rule has been established at the Maryland Lying-in Asylum: All patients without a laceration are confined to the bed for at least 9 days; with a laceration they are confined to the bed for 10 days. No patient is supposed to leave the hospital before the 14th or 15th day, and in the event of some intercurrent disease, the day of discharge is delayed as long as necessary.

IV. MORTALITY.

There have been 252 cases delivered during the last 2 years up to April 5, 1902, in the Maryland Lying-in Asylum. Although our 150 cases show no mortality, two deaths occurred, both last year, one being due to tuberculosis and one to eclampsia, the latter case being in this condition when brought to the hospital. This gives a mortality for the hospital of about .79 of 1 per cent. Considering the circumstances connected with these cases, we may say that the mortality record of the hospital is exceptionally good. The mortality in our 150 cases is 0.

V. MORBIDITY.

The actual morbidity was 24 per cent, the corrected morbidity was 1.33 per cent.

Under actual morbidity are included all the cases which had a temperature over 100.4 except the primary rise when it occurred, from any cause.

Under corrected morbidity are included only those cases in which the temperature was due to puerperal infection.

Conclusions have been drawn under each separate heading. Much more could be said, lengthy discussions entered into, and the subject, puerperium, would yet offer numerous and valuable points for consideration. However, what has been said is sufficient, we trust, to elucidate somewhat the etiological factors which may be productive of an abnormal puerperium.

STRICTURE OF THE OESOPHAGUS.¹

By WM. A. McMILLAN, '03.

Case admitted to the City Hospital, September 8, 1902.

Gracie ———. Nationality, American; age 12 years.

Family History.—Parents both living and in good health. Two brothers and seven sisters living and in good health.

Past History.—Had measles, whooping-cough, chicken-pox and scarlet fever.

Present Condition.—Body very well nourished and organs in good condition. Appetite good and bowels regular.

HISTORY OF THE CASE.

During the summer of 1895 patient drank a quantity of lye which she mistook for water. She was seized with a coughing and choking attack at the time. Domestic measures were instituted for her relief, her mother giving her a quantity of milk to drink which she vomited. The skin peeled off the inside of her mouth. A physician was called and treated her with medicines, but no bougies were passed.

As the months went by she noticed some difficulty in swallowing portions of potatoes and meat. Upon the advice of her physician she was admitted to one of the Baltimore hospitals, where she was anæsthetized and bougies passed. She claims to have expectorated quite a quantity of blood after the passing of said instruments, but some relief was obtained and she left the hospital soon to discontinue the treatment.

About two years ago she was seized with another attack of difficulty in swallowing, which lasted five days. This seemed to be of a spasmodic character and passed off without the passage of bougies. Things went well until last summer, when the trouble returned and she suffered from a complete closure of the oesophagus for a period of eleven days. During this time she did not receive nourishment and became very weak and emaciated. Upon admission to this hospital in September, she was put to bed and a line of restorative treatment adopted, nourishment being given in the form of nutritive enemata for some time.

¹ Read before the Medical Society of the College of Physicians and Surgeons, Nov. 19, 1902.

On the 10th of September Dr. Ruhräh succeeded in getting a small sized bougie beyond the constricted portion. This was followed by a larger one and finally three bougies of more than filiform calibre can be passed beyond the stricture. This method of gradually dilating the gullet has been continued daily with the result shown this evening.

There are times when it is somewhat difficult to get beyond the point of stricture. This is especially noticeable on dark or damp days when even the finest filiform is obstructed for a few seconds. By waiting a few moments and telling the patient to swallow, the instrument will glide beyond the constricted part. It is better perhaps in such cases to let the patient pass the bougie herself, as in this case she has become quite accustomed to the introduction of the same. A slight bending forward of the head and then elevating the chin often aids in getting the bougie beyond the stricture.

In this case the point of obstruction is situated about three inches down the tube and appears to be of the annular variety. In certain places a tiny little sac can be made out against the tip of the bougie. This may only be the obstruction due to a few fibrinous adhesions.

The patient's diet during the treatment, has been of the liquid and mucilaginous variety, under which she has increased markedly in weight.

December 3, 1902. Since reporting the above case it perhaps is of interest to note a few thing in connection with the condition of the patient.

On the 27th ult. patient was permitted to go from the hospital to take Thanksgiving dinner with her cousins. Upon her return to the hospital that evening she was hoarse and unable to swallow. Looking into her throat the following morning I noticed the same to be inflamed and she complained of soreness.

Upon attempting to pass the smallest sized bougie the same was obstructed high up. A gargle of alum (grs. x to the oz.) was ordered. The swelling disappeared and she swallowed without further trouble.

The daily dilation method still goes on with gradual improvement. Patient gaining in weight and in the best of health.

During recent years quite a lot has been said by the various authors of our standard text-books of medicine and surgery regarding this precious piece of anatomy—the œsophagus.

Grey's Anatomy speaks of it as being "a muscular canal about nine inches in length extending from the pharynx to the stomach." I do

not propose to take up your time going into the detailed anatomy of the part, but a better knowledge of the position of the œsophagus is important in order to understand the operations upon this part. It is a continuation of the pharynx and begins opposite the sixth cervical vertebra at the lower border of the cricoid cartilage and extends downwards through the mediastinum and diaphragm to the upper border of the eleventh dorsal vertebra at which place it enters the stomach. Its position at first is in the median line and then soon inclines to the left side at the root of the neck. It then returns to the median line and finally deviates to the left side to perforate the diaphragm. Regarding its histological structure, I would ask you to recall the fact of its being made up of three coats, viz.: an external, middle and internal coat. The external or muscular is made up of a longitudinal and circular layer of fibres, with an intervening layer of nerve tissue. The middle or areolar of loose fibrous tissue and the inner mucous coat has beneath it the muscularis mucosa. Throughout the mucous coat are the œsophageal glands which dip down deeply into the structures.

For practical purposes the conditions producing a stenosis of the œsophagus might be placed under the three following headings, viz.:

Those due to I. Trauma.

Those due to II. Carcinoma.

Those due to III. Syphilis.

Those due to the first class, or traumatic variety, are caused principally by the swallowing, accidentally or with suicidal intent, of strong acids or alkalies. Too hot tea or coffee, alcohol and other liquids of a corroding nature will also produce the same condition. Many articles have been swallowed and lodged in the œsophagus, among which might be mentioned false teeth, pins, needles, jackstones, coins, fish-bones, etc., which through time may produce ulcers and the formation of cicatricial tissue which as a rule results in a stricture of the part. The symptoms upon the swallowing of such articles depends upon the history of the case, and, if one of the corrosives, the amount swallowed. The commonest occurrence is pain upon swallowing, either localized or diffuse and usually lasting but a few days, although a marked degree of discomfort may last for several weeks. The regurgitation of food upon attempted swallowing only occurs in extreme cases of this kind.

Some time may elapse before the formation of stricture and symptoms sufficient to bring the patient before the physician. The usual site of a stricture of this variety is at the beginning of the œsophagus opposite the cricoid cartilage.

PATHOLOGY.

Ewald says, "the mildest pathological effect is a shrivelled and opaque condition of the epidermis. When the disturbances are more severe the superficial portion of the wall is swollen and gelatinous from the action of caustic alkalies, dry and yellow from nitric acid and black from sulphuric acid. This destruction of the tissues may extend even to the muscular coat. After the immediate condition passes away the portion is marked by an œdematous, injected, hemorrhagic zone infiltrated with leucocytes and undermining the dead tissue between the necrotic and relatively normal zone. The sloughs are detached either entirely or in part and later the formation of ulcers which upon healing leave an eschar and finally stricture formation. This is more marked when the corrosives extend to the muscular coat."

Strictures of the carcinomatous variety are found chiefly in the lower three inches of the tube. Cancer is the most frequent cause of disease of the œsophagus and certainly one of the most hopeless. Ewald says, "the disease may extend upwards from the stomach, downwards from the pharynx and inwards from the thyroid." According to Zenker and Von Ziemssen the cancer takes its origin from the lower third of the tube. Sir Morell McKenzie says the upper third is the most frequently affected; but all observers agree that the points most commonly diseased are: the vicinity of the cricoid cartilage, bifurcation of the trachea and the diaphragm.

About three-fourths of the cases are found in men, and of these eight-tenths occur between forty and sixty years of age. The influence of heredity is considered an important etiological factor.

Regarding the pathology of the condition Ewald states that "at first it appears as an isolated, elevated, flattened, rounded nodule, although more than one rarely may be present. This nodule shows extension towards the periphery and tends to encircle the tube." It may involve the whole length of the œsophagus.

The cancer is of epithelial type and just above the same we often get a dilatation of the œsophagus.

The symptoms of this condition are plainly made out as the disease progresses. Pain and difficulty upon swallowing food—especially if the food is of solid variety—is one of the earliest symptoms. Later we get with the increasing condition a dark discharge with regurgitated food, containing blood and pus. If the cancer is situated near the pharynx, the breath becomes very foul. The rapid growth of the tumor and the emaciated condition of the patient, taken into account

with his age, serve well to confirm a diagnosis. The passage of a bougie will reveal a stricture, but such means of diagnosing should be avoided.

The third class of stricture of the œsophagus is produced by syphilitic lesions which as a rule represent the extension of an ulcerative process from the pharynx to the upper part of the œsophagus. Tertiary lesions of syphilis are rare.

Virchow found a characteristic gummous ulceration in which were both the opaque and yellow spots of fatty degeneration and fibrous infiltration. Gummous ulcers have been described extending from the lower end of the œsophagus to the stomach. This condition if not treated will go on from ulcer formation to a stenosis of the gullet and a change in the calibre of the same.

TREATMENT.

The treatment of the above conditions depends first upon determining the cause; when this is known a fair idea can be found of the condition the tube is in. If due to the caustic action of alkalies or acids, as in our case this evening, we can proceed with the bougie method, which is comparatively safe. But, on the other hand, if we are dealing with a case without history of trauma and beyond fifty years of age, we are justified in going slow about the introduction of bougie or tube lest we should puncture the œsophagus at its weak point—as near the seat of a mass of broken-down tissue. A perforation of this kind and the forcing of the tube into the lung tissue or pericardium would undoubtedly prove fatal. Likewise in syphilitic ulcers, one should be careful lest the point of the tube should puncture the gullet at the ulcerated portion. The danger of passing bougies and tubes where an aneurism is present must be borne in mind.

For strictures of the first degree gradual dilatation with use of bougie might therefore be considered the safest and most radical method. Many other schemes have been advised. Some authors advise that intubation of the œsophagus is a valuable method of treatment in cases where the stricture is located in its first portion. Geo. W. Gay, of Boston, considers this method superior to gastrostomy.

External œsophagotomy was first performed by Goursault in 1773. The mortality of the operation is small since the days of antiseptic surgery. The incision is made along the left side of the neck and along the anterior and inner margin of the sterno-cleido-mastoid muscle, just below the cricoid cartilage.

Of the several operations, Abbes' is considered the best. In this

operation the incision is made about two fingers' breadth below the margin of the ribs and a small opening made into the stomach. Then a small sized sound with a silk thread through the tip is passed up from the cardiac end of the œsophagus and out the mouth. The sound is then removed and tension made in both directions with the string—in a manner sawing the stricture. When the obstruction has been divided and the parts admit of a bougie of fairly sized calibre, the stomach and abdominal incisions are sewed up under aseptic precautions and for weeks after the œsophageal passage is kept dilated by the daily introduction of bougies.

In the treatment of the carcinomatous variety, we should, as I stated earlier, be on our guard as to the danger of perforation of the œsophagus. The passage of a small-sized stomach tube and leaving the same in place for a period of a few days at a time has been advised. The patient can in this way be prevented from starving. If the condition is diagnosed early and the cancer found to involve the cardiac end only, an early gastrostomy with the intention of removing all the involved structure may be performed. In this operation the percentage of recurrences is high, but is met with better success now than before the days of aseptic surgery. In this condition, though quite hopeless at times, something must be done for the patient and with rectal feeding, etc., the strength of the patient maintained.

It is advisable in all operative measures upon the œsophagus to nourish the patient for a week or ten days by nutritive enemata.

In the treatment of the third variety due to syphilitic ulcer formation, the patient should be placed as early as possible upon the anti-syphilitic treatment and the same pushed.

The stricture thus caused can be gradually dilated by the daily introduction of a bougie as of the other variety.

For the removal of foreign bodies, etc., that are often the cause of stricture, many instruments have been devised. In the removal of fish-bones and other small articles the horse-hair probang is a very serviceable instrument to have at hand. Forceps with a tip arranged to catch a coin are in use and meet with good results when the foreign body is located high up.

Gentlemen, you see that such a condition as I have endeavored to bring before you calls for heroic treatment in some line or other, and although much has been done in the past for relieving suffering in this direction, I sincerely trust it will be the happy lot of one or more of our men to devise better methods by which pain can be diminished and the mortality reduced in this condition.

WILLIAM S. GARDNER, M. D., EDITOR,
1012 McCulloh Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER,
Mt. Washington.
Telephone, C. & P., Tuxedo, 984.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

ON THE READING OF THE OLDER WRITERS.

One is frequently impressed by the fact that many physicians of the present day both write and speak as if the entire knowledge of the medical sciences had been evolved from the observations and labors of the present generation. By neglecting the older writers they not only miss the inspiration and the pleasure that might be theirs, but they also miss getting a good view of the science of medicine as a whole. They are like the men who, standing on the banks of a stream, admire its swiftness and the depth of its current, without taking the trouble to wander up the picturesque valley and to investigate the many tributaries to which the stream owes its very existence.

A few minutes a day spent with Hippocrates will serve to make them better observers and thinkers, and the same time passed with Aretæus or Paulus Aegineta will open their eyes to the glories of ancient Greek medicine. If any one thinks that the practitioners of a hundred years ago knew nothing of diphtheria, let him read Samuel Bard's little essay on Croup; if the pediatricist thinks that the diseases of children have only been studied during the past two decades, let him read Rilliet and Barthez's wonderful book; or if the public health officer would learn something about Vaccination, let him read Jenner, and if he consults Sydenham and Rhazes he will get some points about small-pox that will probably be new to him. Similar examples might be given without end.

Dr. Osler has said that one should read the new journals and the old books if he would get a good knowledge of medicine. Look up any subject in a modern text-book and then follow the statements back to the men who first observed the fact or suggested the idea, and one is struck by the goodly heritage that has been left to make this age better than the last. Knowing what has been well done and done for all time, the student can devote his energies to those little-worked fields where the harvest is ready for him who will develop methods of investigation.

And then the delight of getting the thing at first hands makes it worth the doing. It is the same as to see for yourself a great man whom you have heretofore only heard about. It is as if one had really met the masters of medicine face to face and had communed with them. And if one is attentive and receptive, a little of the spirit of the masters may descend upon them like

"A light across the sea,
Which haunts the soul and will not let it be,
Still glimmering from the heights of undegenerate years."

R.

PROFESSOR AARON FRIEDENWALD.

On the second of December a memorial meeting was held at the College, which, in spite of the inclement weather, was very largely attended. The meeting was called to order by Dr. Latimer, after which Dr. George J. Preston read the resolutions which had been adopted by the Faculty. The programme consisted of two addresses, which will be found in this number of the JOURNAL. These were delivered by Dr. William Simon and Dr. John Ruhräh.

After the addresses a number of those present paid tributes to Dr. Friedenwald. These speakers were Dr. David Streett, Dr. John D. Blake, Dr. Hiram Woods and Mr. Cummings.

PHI CHI FRATERNITY.

The annual banquet of Delta Chapter, Phi Chi, was held at the Eutaw House on Wednesday, Nov. 26, 1902. It was one of the most

enjoyable social functions yet given by the Fraternity, and made the newly elected members realize that riding the fraternal "goat" has its compensations. Covers were laid for 50. In the absence of Prof. Chambers, President Martin Sullivan acted as toastmaster. Many toasts were responded to, among them "The Student and the Fraternity," Dr. Otto Schaeffer; "Medical Literature," Dr. L. H. Hirshberg; "Modern Medical Colleges," Dr. G. W. Mitchell; "Honor Men," Dr. Albertus Cotton; "New Members," Dr. Albert Conrey. Others who responded were Dr. H. H. Hayden, Dr. Herman Westphal, Dr. S. B. Grimes, Dr. A. Samuels, Dr. Spicknell. Several letters of regret were read from members unable to be present. A business meeting was held at the Fraternity rooms before the banquet and seven new members were "exalted to Phi Chi." The officers of the Fraternity are: Martin Sullivan, president; John J. Fay, vice-president; C. T. Allen, secretary; H. O. Wilmott, treasurer; F. H. Phillips, marshal; G. L. Wyatt, doorkeeper.

Personal Notes.

DR. J. M. LEONARD, '01, is located at Fall River, Mass., and states that he has a good practice for the short time he has been at work.

DR. L. GIBBONS SMART, '85, has been elected to fill the chair of Therapeutics and Clinical Medicine in the Woman's Medical College of Baltimore.

DR. C. O. HERTZMAN, '00, is located at Lindstrom, Minn. He is succeeding well. Last year his practice amounted to \$3000, "and all of it good."

DR. THEO. F. STUART, '79, of Huntington, W. Va., and DR. THOMAS H. O'CONNOR, '93, of Boston, Mass., each sent five dollars to the ALUMNI JOURNAL.

DR. P. H. MULLINS, '82, has sold his practice at Floyd, Va., after having practiced there for eighteen years, and expects to locate at some place in the South.

DR. HENRY R. MCGRAW, '01, was married to Miss Marie Edna Cover, of Baltimore, Oct. 2, 1902. They will reside at 212 South Washington Ave., Denver, Colorado.

DR. WM. J. LYNCH, '94, died in October at Hartford, Conn., as the result of a fall. Dr. Lynch was married to Miss Martha Senger, April 17, 1901. He had a growing practice and a very promising future.

DR. CHARLES W. VOGEL, '95, was in command of the Public Health and Marine Hospital Service at Dutch Harbor, Alaska, during the past summer, but returned to Port Townsend, Wash., at the close of the season of navigation.

DR. JAS. L. YAGLE, '02, New Freedom, Pa., writes: "I am getting along nicely here and have prospects of picking up a good practice in the course of time. I have been appointed examiner for the Prudential Insurance Company."

DR. W. E. MOORE, '81, of Derby, Iowa, writes: "I graduated in 1881 and have been here continuously since that time. I want to come back and do some post-graduate work. If you know of a man of good habits who is a graduate of medicine and dentistry, who wants a good location, tell him to write to me."

DR. W. WAYNE BABCOCK, '94, 3302 North Broad street, Philadelphia, has been announced as the winner of the Maltine prize of a thousand dollars for the best essay on Preventive Medicine. Dr. Babcock's paper is entitled "The General Principles of Preventive Medicine." It will be remembered that in the class of '94 there were two Babcocks, first cousins, and both were awarded a second prize, as they made exactly the same high mark on their examination.

DR. J. J. MCCARTHY, '96, who is traveling for the Chas. H. Phillips Chemical Company, sends us the following news items:

DR. ROBT D. EARLE, '95, died suddenly at a hospital in Philadelphia, Sept. 30. He had been operated on for appendicitis two days previous. Dr. Earle was located at Columbia, S. C., where he had built up a very fine practice. He was a member of the South Carolina Medical Association, and the Medical Society of Columbia.

DR. JOHN J. BARRY, '99, died at his home in Valley Falls, R. I., on Sept. 26, aged 34. Dr. Barry had been ill a long time.

DR. FRANK W. WHITEHEAD, '93, died at Suffolk, Va., Oct. 6, aged 31.

DR. JAMES J. POWERS, '82, a popular and successful physician of Denver, died at Santa Monica, Cal., on Oct. 3, aged 45 years. Dr. Powers had been obliged to go to California on account of a pulmonary trouble and had spent several months there.

At the recent New Jersey State Board examinations, held at Trenton, three graduates of the P. & S. took the same and all of them passed. The averages of the three were 89.2, 87 and 85.1.

CHARLESTON, W. VA., 1902.

DR. CHAS. E. BRACK, Balto., Md.

Dear Doctor.—My memory fails me just before it reaches the point where I subscribed for the JOURNAL. When was it? However, I enclose check and wish you success.

Should you ever be so unfortunate as to be in this part of creation, come to me. W. Va. is full of excellent summer places—springs, spring-boards, spring chickens and spring *beauties*. Come to us and we will do you good.

Yours in the faith Esculapius revised,

A. A. SHAWKEY.

3533 OLIVE ST., ST. LOUIS, Mo., Dec. 5, 1902.

My Dear Brack.—I enclose my annual cart-wheel. The JOURNAL is a source of great pleasure in enabling me to keep in touch with the boys. Dr. F. L. Hoshall, '99, of Franklin, Oklahoma Terr., visited me last month. He did not know of the JOURNAL, and took time to look through the whole file which I have on my shelf. Wish you would send him sample copy, as I am sure he wants it.

Can't you mention the "World's Fair" in the JOURNAL? It is going to be the biggest and best of its kind in history, and is beautiful and imposing even now, when it is little more than half built. I expect to renew many old acquaintances in 1904. It would not be a bad idea for

the various classes to have a reunion here. Or, if we could select a date and call it "P. and S. Baltimore day," and agitate the subject in the JOURNAL and otherwise from now on, we could have a big Alumni reunion and it would be a big card for the school. Then, too, I would like to see the College have the best exhibit in the country, but to do so they should begin now to prepare anatomical and pathological specimens, etc.

The proper display with a vigorous reunion would be of incalculable value to our school and I hope steps in the direction I have suggested may be taken at once and strenuously. If I can do anything at this end, my services are on tap.

This has been my best year, and I have already considerably surpassed last year in income and work.

Remember me to all the boys and boom the school, while incidentally helping the Fair. With best wishes,

Sincerely,

JOHN C. MORFIT.

P. S.—This was written by a typewriter, a brunette, *bald* and *male*.

J. C. M.

PAGOSA SPRINGS, COLO., September 1, 1902.

DR. WM. S. GARDNER, Baltimore, Md.

My dear Doctor.—We are in the land of Indians, saloons, and big bills. The death rattle of The Bath Tub can be heard at all hours. We are having a delightful trip. The waters here are the finest in the world, but the accommodations are quite the contrary, but since we came here for the water more particularly we can put up with the balance, it is right in the heart of the Rocky Mountains. A few days ago they caught two cinnamon bear cubs here. They are fat as butter and playful as kittens. This morning I talked with a bunch of Apache Indians. This week a party of us are going up the San Juan River fishing and hunting. They take many trout here weighing from a pound to 14 pounds, a 3 to 5 trout is fun enough for any amateur fisherman.

We made stops as follows: Washington, D. C., New Orleans, San

Antonio, El Paso, here we made a short side trip into old Mexico. While at Juarez we visited the old Catholic Church 300 years old, also the military prison, bull ring and cock pits. We then crossed the great desert. Here we saw a beautiful image representing a large river with large islands and beautiful trees. We then came into the garden spot of the world, Los Angeles and surrounding country at Santa Monica. Ocean bathing is indulged in throughout the year; at Pasadena we visited the ostrich farm. This was a novel and interesting sight. This is truly a land of flowers and fruits. We saw hedges of geraniums and ear drops from 8 to 12 feet high all covered with bloom. Thousands of acres of oranges, lemons, dates, figs, olives, peaches, pears, plums, apricots, grapes, apples and other fruits. Going from here to San Francisco we went over the new scenic coast route of the Southern Pacific R. R., through the fertile Santa Clara valley. On the Thompson ranch in this valley we saw a lima bean patch of 500 acres. Also 22 horses hitched to a machine that cut, threshed and bagged the wheat as it went along; farming of this kind would make eastern farmers gasp.

At San Francisco we went to the Sutro Baths and Museum, Seal Rocks and Cliff House, the Golden Gates and Strawberry Mountain, several parks, etc. Our trip through Chinatown with its quaint eccentricities was an eye opener. We also visited Presidio, a large military reservation and fort. Coming east, our first stop of any length was at Salt Lake City; heard a sermon in the great Mormon tabernacle with its seating capacity of 7000, its choir of 300 voices, and the largest pipe organ in the world, run by a 10 horsepower electric motor. Were through the Eagle Gates, the Bee Hive and Lion Houses. Also the house Brigham Young built for his favorite wife, Amelia. Were to Young Tomb, the Temple, etc., also to Salt Air Beach where the saltiest of all salt waters on earth is found.

From there to this place we came by easy daylight stages so not to miss any of the superb scenery through the Rockies, stopping at Grand Junction, Montrose and Rico. Rico is located in the mouth of an extinct volcano. It is probably the greatest silver mining town in Colorado.

Our next stop was at Durango, the metropolis of southern Colorado, here we visited the large smelting and refining works, also other places of interest to tourists; after leaving here we will stop at Alamosa, Manitou, Pike's Peak, Garden of the Gods, Colorado Springs, Denver, Chicago and over the Penna. lines to York and home.

Doctor, that small still voice keeps telling me I am in arrears with the payment of my sub. to the ALUMNI JOURNAL, hence a postal money order for \$2.00. Trusting you can use it in your business and that you and family are well, I remain cordially and fraternally yours,

F. J. SNYDER, '87.

SLATE RUN, PA., August 26, 1902.

CHAS. EMIL BRACK, M. D.

Baltimore, Md.

Dear Doctor.—I take pleasure in enclosing one dollar for the ALUMNI JOURNAL, which is very highly appreciated by me. The last issue was especially interesting on account of so much news from the class of '91, of which class I had the honor to be a member. I wish the JOURNAL a successful career.

Sincerely yours,

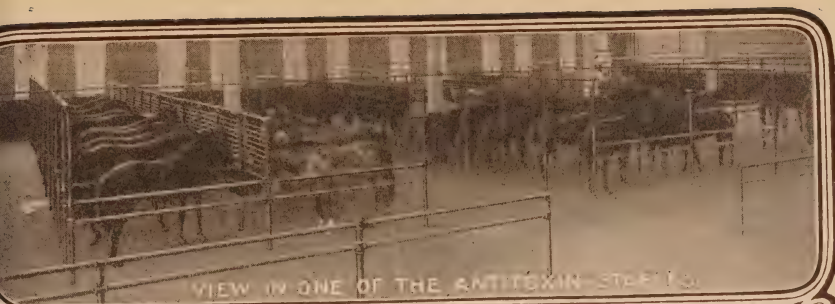
W. E. DELANEY, '91.

ONEIDA, N. Y., August 30, 1902.

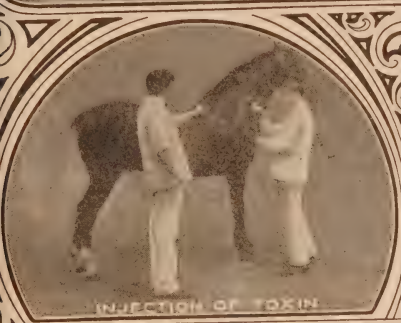
Dear Doctor Brack.—Enclosed find \$1.00 for ALUMNI JOURNAL to April 1, 1903. I have been gratified in learning of the location and progress of the graduates. DR. JESSE HARTSON, '94 died of pneumonia at Ava, N. Y., last year. He had been married only about a year and a half. Soon after his death his only child and his mother died from the same disease. DR. W. B. CLAPPE, '94 is practicing at Victor near Rochester, N. Y., is married, has two children and has an excellent practice. I have just purchased an automobile which to me is a time saver and makes the drudgery of practice less irksome.

Respectfully,

E. H. CARPENTER, '94.



VIEW IN ONE OF THE ANTITOXIN STABLES.



INJECTION OF TOXIN.



ABSTRACTION OF BLOOD.

The Preliminary Steps in Serum Production.

One hundred and fifty horses are housed in the stables of our Biological Department. They are carefully groomed and fed, and close observation is kept upon their physical condition to guard against illness. The stables are under the constant supervision of a skilled veterinary surgeon. They are provided with an abundance of light and fresh air and a perfect system of drainage.

In the process of treatment with diphtheria toxin and of abstraction of blood all appliances are carefully sterilized. The toxin is injected and the blood withdrawn in accordance with the best methods of aseptic surgery.

NOTHING LEFT TO CHANCE.

Before admission to the stables each horse is subjected to a rigid physical examination by an expert veterinarian.

The tuberculin and mallein tests are applied to exclude tuberculosis and glanders.

The animal is kept for ten days under strict surveillance in an isolation stable and rendered immune to tetanus by treatment with antitetanic serum.

Each lot of our *Antidiphtheritic Serum* is placed in cold storage, and the horse from which it was drawn kept under close observation, until the fact is established that the animal was in perfect health.

We market our product in hermetically sealed glass bulbs, and every lot is physiologically and bacteriologically tested.

In the preparation of Parke, Davis & Co.'s Antidiphtheritic Serum the element of guesswork never enters. To insure its purity and potency we resort to every precaution, every available test.

LABORATORIES:
Detroit, Michigan, U. S. A.
Walkerville, Ont., Canada.
Hounslow, England.

PARKE, DAVIS & CO.

BRANCH HOUSES:
New York, Kansas City, Baltimore,
New Orleans, Chicago;
London, Montreal, Sydney (N.S.W.)

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, N. Y., Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S. Ohio.
E. PARMLY BROWN, D. D. S. N. Y.
A. L. NORTHBOP, D. D. S. N. Y.
E. L. HUNTER, D. D. S. N. C.
W. W. WALKER, D. D. S. N. Y.
OSCAR ADELBURG, D. D. S. N. J.
G. MARSHALL SMITH, D. D. S. Md.
C. M. GINGRICH, D. D. S., Resident. Md.
J. HALL MOORE, D. D. S. Va.

R. B. DONALDSON, D. D. S. D. C.
H. A. PARR, D. D. S. N. Y.
J. EMORY SCOTT, D. D. S. Md.
C. L. ALEXANDER, D. D. S. N. C.
M. M. MAINE, D. D. S. Conn.
J. W. DAVID, D. D. S. Texas.
A. C. BREWER, D. D. S. Md.
J. ROACH, D. D. S. Md.

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

W. W. DUNBRACCO, D. D. S. J. K. BURGESS, D. D. S. J. C. SUTHERLAND, D. D. S.
GEO. V. MILHOLLAND, D. D. S. CHAS. THEBERATH, D. D. S.
L. M. PARSONS, D. D. S. HARRY E. KELSEY, D. D. S. C. H. CARSON, D. D. S.
H. M. LEVER, D. D. S. C. S. GORE, D. D. S. L. F. PALMER, D. D. S.
C. R. STEWART, D. D. S. L. D. CORIELL, D. D. S.
H. H. HAYDEN, M. D., Demonstrator of Anatomy.
C. F. BLAKE, M. D., Demonstrator of Anatomy.

The Sixty-Third Annual Session will commence on the 1st of October, 1902, and continue until May, 1903.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.

MULFORD'S GLYCERINIZED VACCINE

"ALWAYS TAKES"

Yields 100% SUCCESSFUL VAC-
CINATIONS IN
PRIMARY CASES

Supplied in complete outfit containing
scarifier, bulb for expelling lymph from
capillary tube and 10 tubes **\$1.00**
of Glycerinized Vaccine . . .



*Literature mailed upon request
Supplied by all reliable druggists*



H. K. MULFORD COMPANY

CHEMISTS

Philadelphia

New York

Chicago

College of Physicians and Surgeons OF BALTIMORE.

— FACULTY —

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- AARON FRIEDENWALD, M. D.,
Professor of Diseases of the Eye and Ear.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Medical Jurisprudence and Director of Pasteur Institute.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, A. B., M. D.,
Professor of Obstetrics.
- WM. ROYAL STOKES, M. D.,
Professor of Pathology and Bacteriology.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- C. HAMPSON JONES, M.B., G.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- HARRY FRIEDENWALD, A. B., M. D.,
Associate Professor of Diseases of the Eye and Ear.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MCLEARY, M. D.,
Associate Professor of Histology and Pathology.
- CHARLES E. BRACK, M. D.,
Associate Professor of Obstetrics.
- JOHN RUHRÄH, M. D.,
Clinical Professor of Diseases of Children.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Clinical Professor of Diseases of the Rectum.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MOGLANNAN, M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- MELVIN ROSENTHAL, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- ALBERTUS COTTON, M. D.,
Associate Professor of Orthopedic Surgery.
- ARCHIBALD C. HARRISON, M. D.,
Demonstrator of Anatomy.
- GLENN M. LITSINGER, M. D.,
Demonstrator of Obstetrics.
- A. SAMUELS, M. D.,
Demonstrator of Chemistry.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- JOHN MASON KNOX, JR., M. D.,
Demonstrator of Pathology and Physical Diagnosis.
- CHARLES B. CANBY, M. D.,
Demonstrator of Pathology.
- OTTO C. GLASER, A. B.,
Demonstrator of Embryology.
- L. H. HIRSHBERG, A. B., M. D.,
Demonstrator of Bacteriology and Assistant in Neurology.
- C. W. G. ROHBER, M. D.,
Demonstrator of Pathology and Resident Pathologist.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Assistant in Genito-Urinary Surgery.
- OTTO SCHAEFER, M. D.,
Assistant in Eye and Ear Diseases.
- HERMAN WESTPHAL, M. D.,
Assistant in Surgery.
- W. EDWARD MAGRUDER, M. D.,
Assistant in Diseases of Children.
- L. J. ROSENTHAL, M. D.,
Assistant in Diseases of Stomach.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1893, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,
CALVERT AND SARATOGA STREETS,
BALTIMORE, MD.

Issued Quarterly

Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION

OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS

BALTIMORE.

Vol. VI

No. 1

APRIL, 1903

PUBLISHED AT
Baltimore and Eutaw Sts. Baltimore, Md



~~5-7262~~

ANNOUNCEMENT
OF
POST-GRADUATE COURSES
FOR
PRACTITIONERS OF MEDICINE

Beginning May 1st, 1903, and continuing for six weeks. These embrace courses in *Medicine* (including daily visits to the medical wards), *Pediatrics* and *Nervous Diseases*, *Surgery* (general, orthopedic, genito-urinary surgery and cystoscopy), *Gynecology*, *Operative Obstetrics*, *Ophthalmology* (including a course in the use of the Ophthalmoscope), *Otology*, *Laryngology*, *Pathology* (Demonstrations of fresh specimens and microscopic course), *Bacteriology* and *Clinical Laboratory* courses in the microscopic and chemical examination of the blood, urine, gastric juice, feces, etc., etc.

These courses *are entirely* practical.

A certificate of attendance will be given at the end of the course.

For schedule and further information apply to

DR. HARRY FRIEDENWALD, CHAIRMAN,

College of Physicians and Surgeons,

BALTIMORE, MD.

4105-

The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department.*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,

CATONSVILLE, MD.

REFERENCES:

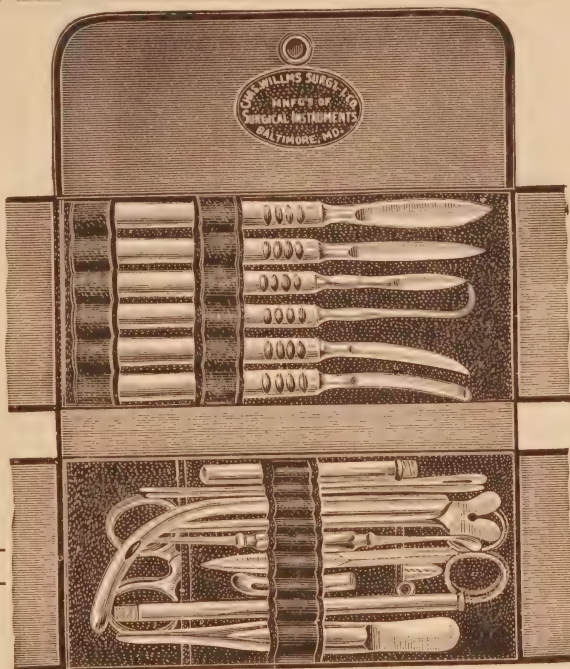
Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
Vaginal Operation for Extra Uterine Pregnancy: Dührssen's Method. DR. WILLIAM S. GARDNER,	1
A Review of Some Interesting Work on Infectious Diseases. DR. JOHN RUHRÄH,	6
A Contribution to the Pathology of Chorea. DR. LEONARD K. HIRSHBERG,	10
Albrecht von Graefe. EDGAR B. FRIEDENWALD,	14
A Case of Small-Pox in Utero. DR. H. W. B. ROWE and E. B. FRIEDENWALD,	20
Tetany.—Report of a Case. G. L. VIEWIG,	21
Behring's View of the Identity of Tuberculosis of Human and Bovine Origin,	22
On the Educational Value of the Medical Society,	23
Editorial,	25
Personal Notes,	iv, 28
Deaths,	29
Correspondence,	29

**"OUR
LEADER."**

Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.



All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

**THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,
MANUFACTURERS AND IMPORTERS,**

300 N. HOWARD STREET, - - - BALTIMORE, MD.

PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES.
111

Personal Notes.

DR. E. A. HOFFMAN, '96, has located in Rochester, N. Y.

DR. W. H. SHOCKFORD, '78, has removed to Roanoke, Va.

DR. D. V. SMITH, '00, has a good practice at Letart, W. Va.

DR. B. F. LEONARD, '97, is practicing dentistry at Plainfield, N. J.

DR. E. H. WHITE, '91, is president of the Obion County (Tenn.) Medical Society.

DR. J. W. LACY, '96, has been elected president of the Howard County Medical Society.

DR. A. SAMUELS, '98, was married Tuesday, March 31, in New York to Miss Rose Leah Bloomberg.

DOES EVERYTHING

that *syrups* of hypophosphites do, that is beneficial.

DOES NOTHING

that *syrups* of hypophosphites do, that is detrimental.

AROMATIC SOLUTION OF HYPOPHOSPHITES.

Manufactured by
HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

Pint samples furnished upon application.

LAPACTIC PILLS

R

Aloin, S. & D.	gr. $\frac{1}{4}$
Strychninae,	gr. $\frac{1}{80}$
Extr. Belladonnae,	gr. $\frac{1}{6}$
Ipecacuanhae,	gr. $\frac{1}{16}$

M: et ft. Pil. No. 1.

The best and most reliable laxative pill ever offered the profession. The formula and name were originated by us, and because of the freedom of our Aloin from any resin of aloes or resinified aloes, due to our manufacturing it ourselves, Lapactic Pills never gripe and never fail. This cannot be said of the many substitutes offered the profession and the trade. Hence, please specify on your prescriptions and orders

SHARP & DOHME

CHICAGO.

BALTIMORE.

NEW YORK.

NEW ORLEANS.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

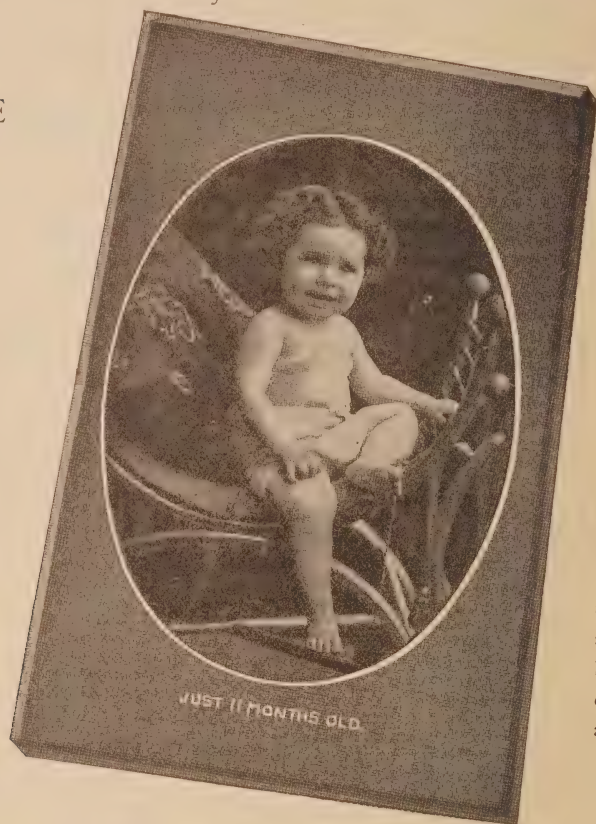
THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap has been used exclusively in this baby's bath from birth, and her perfect skin and luxuriant hair excite wonderful interest and admiration.

AS A NUTRIENT SOAP
FOR THE SKIN

Resinol Soap

IS WITHOUT A PARALLEL.

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.,
SYDNEY, N. S. W.
Agents for Australasia.

LIBRARY OF THE
THE JOURNAL
OF THE ALUMNI ASSOCIATION
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

VAGINAL OPERATION FOR EXTRA-UTERINE PREGNANCY:
DÜHRSSSEN'S METHOD.

By DR. WILLIAM S. GARDNER, '85.

In this country the vaginal operations for extra-uterine pregnancy have few advocates. A considerable number of so-called hematocele cases have been opened and drained, but very few attempts have been made to remove the ruptured tube through the vagina. Nearly all American operators believe in approaching all cases of tubal pregnancy through the abdominal wall. But the fact that the vaginal operation is not done here is no argument that it is not a good operation or that our own methods are better.

When an operation for a condition as dangerous to life as is extra-uterine pregnancy has been performed sixty times, and sixty patients have recovered after detention in hospital of only two weeks, it is certainly deserving of consideration.

My attention has been recalled to this subject by an article by Strassman in the Berliner Klinische Wochenschrift for June, 1902, in which he reviews the various methods of treating extra-uterine pregnancy and reports in detail nine cases upon which he operated through the vagina. Five of these operations were done through the anterior and four through the posterior vaginal wall. Of these nine patients three were nullipara

and six had borne children. Four patients had aborted and one had had a premature birth. He states that he learned much from one case of fresh rupture because up to the time he had this case he had always been of the opinion that in these cases life could be saved only by laparotomy. This patient had lost so much blood into the abdominal cavity that she was not even able to sign her name. From this patient he removed through the posterior vaginal wall the right adnexa and broke up the adhesions about the left tube. The patient was discharged on the 20th day.

With exception of one case he removed the tube. In this case he cut open the tube, removed the ovum, curetted the place of attachment, sewed up the tube and returned it to the pelvis. This evacuation of the tube has been done by Porchownik, Martin, Jung. Bröse has even once pressed out an ovum from the fimbriated end of the tube.

In the preparation of the patient he recommends that they be treated the same as other gynecological patients, except that in cleaning the vagina only soap followed by lyposoform one per cent be used, and states that the use of alcohol and sublimate solutions make the operation more difficult.

A narrow vagina can be dilated by the fingers very much as the sphincter of the anus is dilated. He found it necessary to incise the perineum in only one case, although he had operated upon three nullipara.

He opens the anterior or posterior vaginal wall according to where the tumor lies. The presence of adhesions is ascertained by the introduction of the finger just as is done in operating through the abdominal wall. The tumor is then brought forward and the adhesion broken up under the eye. Adhesions to the rectum are more easily broken up from below than from above. Also one has to contend with only the lowest adhesions, while in the laparotomy it is necessary to break through more adhesions.

The drawing forward of the tube is generally not difficult, because the ligaments on account of the pregnancy are soft and relaxed. To assist in bringing forward the tube he uses one hand over the abdominal wall as in the usual bimanual manipulation. He has never found it necessary to open the abdomen, although preparations are always made for that emergency, as he notes that Baldwin has done with good results.

After the operation the patient remains in bed twelve to fourteen days. The mortality is nothing. The vaginal operation is indicated in the most severe hemorrhages. The operation is as rapid through the vagina as through the abdomen.

In discussing this paper of Strassman's Dührssen stated that he had operated upon 36 cases by anterior colpoceliotomy and all had recovered. He does this operation in all cases.

To learn exactly how he does the operation it is necessary to go back to his paper published in 1897. Dührssen, in the Archives for Gynecology, 1897, in an elaborate article on extra-uterine pregnancy, gives in detail the technique of the vaginal operation as he performs it. He describes the operation in four steps:

I. The opening of the abdominal cavity through the anterior vaginal wall.

II. The extraction of the adnexae.

III. The ligation and removal of the adnexae.

IV. The closure of the peritoneum and the opening in the vaginal wall.

The preparation of the patient is just the same as in other operative cases, a one per cent Lysol solution being the only antiseptic used.

I. After the introduction of a Simen's speculum into the vagina the cervix is seized by a bullet forceps, drawn downward to the introitus and a small transverse incision is made. The wound is then enlarged to each side with the scissors until a transverse incision 3 or 4 cm. long is obtained.

In multipara it is easy to separate the bladder from the uterus by dissecting with the finger until the peritoneum can be felt. In nullipara after separating the vagina from the cervix it is frequently necessary to penetrate a dense layer of tissue a quarter to a half centimeter thick. When it is not possible to get through this dense tissue by blunt dissection it is necessary to cut through it with the scissors, the incision being directed toward the uterus.

Through the separation of the bladder from the uterus it is usually also separated from the vaginal wall, so that by the introduction of the first and middle fingers the anterior vaginal wall can be cut through almost to the meatus without danger of injuring the bladder. This T

incision is made so as to be able to make a long sagittal incision in the peritoneum.

The upper end of the long incision is fixed with a bullet forceps.

Before one proceeds to open the peritoneum it is necessary to be sure that only the peritoneum remains to be opened. It is recognized as a yellowish white membrane. If on raising the tissues with the forceps a red membrane presents itself, then either the bladder or the retrovesical tissue is held and the blunt dissection must be carried higher. In extra-uterine pregnancy if there is free blood in the abdominal cavity or an ante-uterine hematocoele the peritoneum presents a bluish-black appearance.

A small fold of the peritoneum is taken up and opened with the scissors. A second forceps is introduced into the opening and between the two the split is extended downwards to the internal and upward as far as can be seen. The upper end of the peritoneal opening is grasped with two pairs of forceps and drawn downwards. With the peritoneum comes some retrovesical fat which it is best not to wound and so cause unnecessary bleeding. This tissue is pushed out of the way with a blunt instrument, and the peritoneal opening extended upward one or two cm. In this way the peritoneum is opened still further and the wound is such that at the end of the operation the whole peritoneal opening can be drawn forward and accurately sewn. Three thin catgut ligatures are introduced into the peritoneal wound, one at the upper angle and one on each side about one centimeter lower.

II. *Extraction:* The assistants simultaneously draw downward and upward on the bullet forceps and upward and sidewise on the ligatures to open as widely as possible the incision. A retractor is introduced into the opening and with a bullet forceps the highest part of the anterior wall of the uterus that can be seen is grasped. The forceps on the cervix are removed and the cervix pushed backward with the posterior speculum. By this manipulation and traction on the forceps fixed in the anterior wall a higher portion of the uterus comes into view and a second bullet forceps are inserted. In this way unless there are adhesions or other obstructions the uterus can be extracted with from one to four

forceps. The extraction is made easier if the assistant draws strongly upwards on the anterior speculum.

In extra-uterine pregnancy it is not so much the smallness of the opening as it is the softness of the uterine wall which allows the bullet forceps to pull out that gives difficulty in the extraction. In these cases a ligature can be passed through the wall as a tractor in place of the forceps.

When the fundus is once in the vagina it is best to fix it with a fine vulsellum forceps.

All of this is done under the eye and there is no operating in the dark and uncontrollable tearing of tissues as has been charged.

It is generally possible by making strong traction on the uterus downward and to one side to bring the ligament of the opposite side into the middle line, so that with the finger the tube and ovary can be brought out into the vagina and at once tied off.

III. LIGATION AND REMOVAL.

Dührssen uses only catgut which he ties very tightly. The first ligature is put around the ovarian ligament and tied. This suture allows the ligament to be drawn further forward and one or two more sutures are introduced into the broad ligament. The isthmus is now tied off with a fine ligature. The large vessels are tied en-masse and the adnexae removed.

IV. CLOSING THE WOUND.

Before closing the wound the uterus is replaced, but this is usually very easily done. The provisional sutures in the upper angle of the peritoneal wound are drawn upon, bringing the angle into view and beginning there a continuous catgut suture closes the peritoneum. If during the operation these provisional sutures are torn out the peritoneum can be closed by interrupted sutures beginning below. After the peritoneum is closed, the vaginal wound is brought together by two continuous sutures. A strip of iodoform gauze is laid in the vagina, which is removed the next day; on the third day castor oil is given; the patient is usually out of bed on the ninth or tenth day and goes home the day following.

A REVIEW OF SOME INTERESTING WORK ON INFECTIOUS DISEASES.

BY DR. JOHN RUHRÄH, '94.

Before the Medical Section for the Diseases of Childhood at the Thirteenth International Medical Congress held in Paris in August, 1900, M. Grancher, Professor of Diseases of Children, of the Paris Faculty, presented a remarkable paper which, so far as I know, has not received much attention in the American medical journals.

M. Grancher's paper is short and to the point and contains some truths concerning the transmission of infectious diseases that are worthy of further study. It deals with his own experiments made in his wards at the Hôpital des Enfants Malades. Having had an opportunity of seeing these wards, I feel sure that a review of the work will be of interest.

Ten years ago M. Grancher wrote the following sentence: "The prophylaxis of contagious diseases is one of the most interesting questions of contemporaneous medicine. In the hospital, in the home and in the family the question is posed in about the same manner. It deals with the protection of the neighbors of the patient, those who nurse him and surround him, from contagion. It deals also with the protection of the patient himself from his neighbors and himself in avoiding the secondary infections which are always so formidable. For this we have two means: *isolation* and *antisepsis*."

After having written thus he proceeded to try some very interesting experiments along this line. Arguing that surgical and obstetrical infection had been reduced to a minimum by the adoption of a suitable technique, he proceeded to develop a medical technique, and as a result he has come to the following conclusions:

Antisepsis and with it isolation of the patient, even if imperfect, gives excellent results. Without antisepsis, isolation, even if individual and in separate rooms, does not stop contagion.

This gives good results for all infectious diseases except measles and chicken-pox. In measles and chicken-pox the infections are diminished in the proportion of three to one.

Air infection does not exist where the children do not expectorate and where the dust is suppressed. On the contrary, infection is by infected objects, that is to say, by contact, direct and indirect.

In order to avoid infections it is necessary to purify immediately the hands and objects soiled by contact necessary in the examination and care of the patient, and secondly to diminish contact with children with infectious diseases and with those supposed to be infected.

The service of M. Grancher has been organized since 1888. He does not remove cases of infectious diseases developing in his wards to the infectious pavilions, but treats them in the same room with the other patients with astonishingly good results.

This he could not do had he not very faithful assistants and nurses and those about him who are interested in the success of the work. Without assistants of like devotion such a plan would work havoc in a hospital.

The first care was the suppression of dust. To do this the floors are paraffined and are washed twice daily with a solution of sublimate. The walls are painted and are washed twice a week with sublimate solution.

The second care is the isolation of the patient. In order to accomplish this a metal screen 1.25 metres high surrounds the bed. One end is left open so that it may be entered. On entering the screen both physicians and nurses are gowned, and on leaving, the hands are disinfected by washing with soap and brush and the using of a 1-1000 solution of sublimate; the gowns for each patient are hung on the screens of the respective beds. All mattresses and bedding are sterilized by steam, and all the linen and articles used for feeding are boiled in water. The food is served on wire trays having a handle. On these trays are placed the bowl and saucer, knife, fork, spoon and napkin. After feeding the whole is placed in a pot of water with a little carbonate of soda and boiled for five minutes. This gives a temperature of 103° C. The beds are of iron and are disinfected by scrubbing with an acid solution of sublimate and a brush.

It is interesting to note that the nurses handle all cases, both infectious and non-infectious. To start with there was a separate nurse for the contagious cases, but later on it was found that the work of the ward

required her assistance, so all the nurses were allowed to wait on the infectious cases. All of them naturally take the same rigid precautions. Some of the cases developing in the hospital were due to the fact that the night service was rendered by the youngest nurse in the ward and also that there was but one night nurse.

A number of infections could be directly traced to importations by visitors. In order to avoid the introduction of contagion by new cases all the children are regarded as suspects and are isolated behind screens just like the contagious ones. If at the expiration of twenty days they have not developed anything they are released.

The results of this means of caring for contagious cases may be briefly summarized as follows:

Measles.—During 1885, 1886 and 1887 there was an average of 36 cases of measles developing in the wards. During the decade following under the special precautions the annual average has been 11. Without giving the detailed figures it may be stated that the coefficient of infection for measles where special precautions were taken was 0.01. For the other wards of the hospital it was 0.02 or 0.03. The decrease of infections with the special precautions was about 3 to 1.

Varicella.—This disease, with about the same contagiousness as measles, shows about the same result.

Diphtheria.—Here the results are very remarkable. Previous to the careful work of isolation and antiseptics there was an average of 12 infections in each of two wards per year. Afterwards, during the next ten years, in one ward there was not a single case of infection, and in the other ward there were only 6 cases, 5 of which were imported by visitors. In other words, infection from the cases of diphtheria was practically done away with. It must be understood that there were cases in the ward during these ten years, but they came in either as developed cases or during the stage of incubation.

Scarlatina.—In four ordinary wards during ten years there were 99 cases of scarlet fever. In the two wards where the experiments were tried there were only 7; three of these were importations. Scarlet fever infection was therefore practically controlled.

Whooping-cough, Mumps and Broncho-pneumonia.—All three of these were practically entirely suppressed.

SALLE BOUCHUT.

Table for Ten Years, 1890-1899.

Disease.	Cases Entering in Incubation or Evolution.	Contagions by Importation.	Contagions in the Service.	Total.
Measles.....	66	9	13	22
Diphtheria.....	26	5	1	6
Scarlatina.....	13	3	2	5
Whooping-cough.....	154		4	4
Broncho-pneumonia.....	138			
Varicella.....	57	4	13	17
Mumps.....	15		1	1

SALLE PARROT.

Table for Ten Years, 1890-1899.

Disease.	Cases Entering in Incubation or Evolution.	Contagions by Importation.	Contagions in the Service.	Total.
Measles.....	75	6	51	57
Diphtheria.....	17			
Scarlatina.....	6	1		1
Whooping-cough.....	203		3	3
Broncho-pneumonia.....	102			
Varicella.....	72		22	22
Mumps.....	8			

These results are very much what we might have anticipated for the most part. The notable exception is whooping-cough, where it has been the experience of most observers that the contagious principle was

diffused through the air and where cases have been reported of infection in the open air without direct contact.

Along the same line of work in infectious diseases is the new hospital at the Pasteur Institute in Paris. In this the various diseases are received in the same building, but there they are managed with room isolation and strictest antiseptic precautions. At the time of my visit, seven months after the installation of the plant, there had not been any cross infections in the patients after they had been admitted to the hospital. The cases of measles were kept entirely separate from the others. If I am correctly informed no cases of chicken-pox had been admitted. There had been, however, a large number of small-pox patients received and treated.

A CONTRIBUTION TO THE PATHOLOGY OF CHOREA.

BY DR. LEONARD K. HIRSHBERG.

Included under the name of chorea are many and various diseased conditions, characterized more or less by involuntary movements and muscular contractions of a complicated nature. These different diseases often require considerable skill to sharply differentiate them. Sydenham's chorea or chorea minor occurs more especially in childhood and adolescence, most commonly between the fifth and fifteenth years; no time of life, however, is without it. Senile chorea, as far as our present knowledge indicates, is of precisely the same nature as Sydenham's chorea. Chorea major or magna is an hysteric condition, in no respect like the above affection. Chorea hysterica is a condition in which hysteric muscular contractions predominate the case. Chorea simulative is not always a true chorea, but one of the hysteric conditions, although true chorea is said to occur by imitation in some places, such as schools, where epidemics are frequent.

The chorea of pregnancy is usually the true chorea minor. It may arise in previously healthy individuals or in those who have before had chorea. It is so closely related to pregnancy that it ends with the termination of pregnancy.

Traumatic chorea may be a true Sydenham's chorea or a post-hemiplegic chorea. The latter form of involuntary movements follows a

hemiplegia. Charcot also recognized a pre-hemiplegic chorea from a slowly progressive hemorrhage into the thalamus.

Hemichorea expresses itself in involuntary muscular contractions limited to the limbs on one side of the body and producing a trembling and awkwardness which passes from one muscular group to another.

Under the name electric chorea, various obscure disease conditions have been included. Dubini described a disease occurring in upper Italy characterized by a sensation of pain in the head, neck or spinal cord followed by rapid spasms similar to those produced by an interrupted current. In days, weeks or months death results from heart failure or coma. Few cases recover. Henoch's chorea is distinguished from ordinary chorea by the lightning or electric-like character of the contractions. These occur principally in the neck and shoulder muscles.

Bergeron's electric chorea differs widely from the above. The characteristic symptom is violent spasms occurring in impulses. It is supposed to depend upon gastric irritation.

Oppenheim and Kemals describe an hereditary hemichorea which gradually becomes a chronic progressive chorea, extending over every muscular group.

Huntington's chorea must be clearly separated from other forms of chorea. It begins in middle life and is passed on from generation to generation. The motor phenomena are at first slight and limited to the face or upper limb, but later include the whole muscular system.

The pathology of ordinary or Sydenham's chorea is still obscure. Many theories have been advanced to account for the disorder. The association which exists between chorea, acute rheumatic fever, endocarditis and tonsillitis has attracted much attention ever since Dr. Osler first called attention to the frequency of endocarditis in chorea. Opinions still differ, but it is a completely established fact that chorea occurs very often after or with acute articular rheumatism. In fact one of our leading authorities upon chorea advises in the absence of articular involvement that the joint pains have either been overlooked or so slightly painful as to have been neglected. In any case, if the joints have not given any evidence of involvement, the tonsils most assuredly have. Endocarditis is present in almost every case, but not all.

Some observers indicate that embolic material passing from the heart to the brain, causes occlusion of the small vessels, and circumscribed areas of softening which arise produce motor symptoms of irritation. As a matter of actual observation, however, emboli have been observed in only a few cases. Bechterew regards chorea as due to an infectious process and Berkeley, Dana, Richter, Meyer and Dr. Osler found evidence of bacteria in the brain in some cases. Pinanese found a coccus which he cultivated and succeeded in reproducing an experimental chorea.

In spite of the trend of opinion at present, chorea minor is still classified in all text-books on medicine as one of the neuroses, and has not yet been placed among the infectious diseases.

Preoprajensky recently obtained streptococci in pure culture from three cases of chorea. He published the results of his discovery in *La Semaine Médicale*, December 10, 1902.

It occurred to me when I read this, that it would not be at all surprising if the streptococcus was a possible etiological factor in chorea, for it has been found often associated with acute articular rheumatism and endocarditis. In tonsillitis, the streptococcus is the most frequent organism found, and when one considers the association of these conditions with chorea, and the recurrence of tonsillitis and the recurrence of rheumatic fever, endocarditis and chorea, it would be almost a natural deduction to expect to isolate the ubiquitous streptococcus.

Acting upon these principles, cultures were taken with the kind assistance of Dr. Hay, of St. Louis, and several students, from three patients suffering with chorea minor. One other patient visiting the City Hospital Dispensary at the time refused to allow us to take a culture from his blood.

E. M., aged 6, female, came to City Hospital out-door department January 9th. Complaint was St. Anthony's dance. F. H. F. a drunkard. M. l. & w. P. H. negative. P. I. began two weeks before. Dropped knives at the table. Teacher said she became restless and jerky at school. Noticed jerks, irregular movements, could not sit still, thought she had worms, etc. P. C. P. r. to l. and accom. Tongue coated with white, moist fur. Protrudes in mid-line, jerked in and

out. No nystagmus. Involuntary, purposeless movements of facial muscles, fingers, feet, arms, etc. Choreic twitchings increased on voluntary movement, movements vary constantly, etc. . . . Lungs clear. Heart not enlarged. Slight præcordial bulging. At apex a distinct thrill. Loud blowing systolic murmur with snapping first sound, faint murmur towards end of diastole. No mental disturbances, etc. Temp. 99.8°. Pulse 112.

Under careful aseptic precautions and antiseptic treatment of the skin over the median basilic vein of right arm, ten cc. of blood were drawn and divided equally into four Florence flasks containing each 200 cc. of sterile bouillon. These were incubated at 37.5° C. and when examined two days later had no growth and remained sterile.

The patient was given a ten cc. injection of anti-streptococcic serum and placed in bed. There was considerable reaction, the temperature arose to 102° and profuse perspiration lasted some time. The same injection was repeated every other day until ten doses had been given. The patient remained in bed during the entire treatment and at the end of three weeks had completely recovered from the chorea. The only other treatment during this time was an icebag over the præcordium.

M. R., aged 9, colored male. Showed no cardiac disturbances, but besides the many and various movements, grew very obstinate and violent at times. His illness began three weeks before admission. Was taking five drops (arsenic?) three times a day when first under observation. Cultures taken as above showed pure growths of streptococci, in short chains and pairs. His temperature was 101.2° when first observed and he had a general glandular enlargement. It was impossible to keep him in bed. In all he received four injections of the anti-streptococcic serum, and although his mental symptoms cleared and he became more tractable, the choreic movements are still more or less present after two months. The syrup of the iodide of iron seems to be lessening the twitchings more than the arsenic or serum did.

M. R., aged 12, Russian male, has had two previous attacks of chorea with endocarditis and rheumatism. Admitted into the City Hospital March 17. Could not be kept in bed, sent home on 21st. Cultures

taken from blood showed streptococci and the white staphylococcus, probably a contamination. Dr. Sam. Holden also saw this patient with me at his home. He was very violent and threatened to jump from his window in the second story. His arsenic was stopped and anti-streptococcic serum given. His movements increased and he became so violent that it became necessary to have some one always with him. The family attributed this increase of symptoms (perhaps justly) to the injections, so the patient was again placed under the arsenic treatment with a happy result.

A fourth case is now under observation, but so far the results are doubtful.

From the foregoing, it can be seen that the favorable results obtained in France with the anti-streptococcic treatment have not been substantiated in my hands. It seems that in the greatest number of cases arsenic is the nearest approach to a specific, at present obtainable.

ALBRECHT VON GRAEFE.

By EDGAR B. FRIEDENWALD, '03.

Albrecht von Graefe was born at Berlin, May 22, 1828. His father Carl Ferdinand von Graefe was both a famous surgeon and oculist and at the time of his death Professor of Surgery and Ophthalmology at the University of Berlin.

His father dying when Graefe was but twelve years of age, his rearing was left to his mother. She had the satisfaction of seeing her son quickly rise to become one of the famous men of his time, and the sorrow of seeing him die in the prime of his life and in the midst of his labors.

He grew up under the most favorable surroundings and throughout his entire life he neither knew what want or what privation meant.

Through private instruction furnished at home he was able to fulfill the gymnasium requirements brilliantly at the age of sixteen.

During his school days he showed the same intellectual characteristics which made his future work so fruitful. He showed remarkable reasoning powers and mastered the hardest problems with extreme rapidity. His favorite branch was mathematics.

Already at this time he had developed those endearing qualities which made every one, coming in contact with him, love him.

He entered the University of Berlin in the fall of 1843 to take up the study of his self-chosen profession of medicine. At this time the medical faculty of the University contained many noted men, among whom were Johannes Miller, Dieffenbach, Schoenlein, Schlemm and Romberg. In 1846 Rudolph Virchow became Prosector at the Charitè, and for the first time demonstrated pathological anatomy to the Berlin students from fresh specimens.

Graefe had the highest respect for his teachers, but the one of whom he thought the most was Rudolph Virchow. He showed the greatest interest in Virchow's lectures, as he did also in his first work, which appeared in 1845-47. The present method of teaching medicine by observing the clinical course of the disease on the one hand and its pathology on the other we owe to Virchow. Graefe had the good fortune of being one of the first upon whom Virchow impressed this and we can notice its influence in all his work.

Graefe also attended at this time Professor Junker's eye clinics at the Charitè. This was the only eye clinic held in Berlin from the time of the death of Graefe's father until the establishment of his own.

On August 21, 1847, when not quite twenty years old, Graefe received his degree. His thesis on this occasion was "Bromine and Its Compounds." In it he described the chemistry, physiological action, and the therapeutic applications.

In 1848 he passed his "States" examination, where he received the testimonial "Excellent."

In the autumn of this year Graefe began a two years' tour of the important medical centres for the purpose of finishing his education. He first visited Prague. Here he studied under Ferdinand Arlt, and through his influence he determined to take up ophthalmology, and thereafter most of his studies were directed in that line. He then visited the clinics of Sichel and Desmarres at Paris, those of the von Jaeger's at Vienna and those of Bowman and Critchett at London. The most important part of this time was spent at Prague under Arlt, of whom Graefe has the following to say: "When I look back upon my ophthal-

mological studies I always repeat to myself how much I have to thank good Arlt for, both as teacher and as friend. He introduced me into ophthalmology. He impressed upon me the same solid principles which he himself followed in the practice of his specialty. He was the first to show me how an eye operation must be carried out. Believe me, without Prague, Paris and Vienna would have hardly done me as much good. Yes, I believe that without Arlt I would probably not have returned to Berlin as an ophthalmologist."

On November 1, 1850, Graefe returned to Berlin and opened an office on the second floor of an insignificant dwelling on Behrenstrasse. In the front room, which he used for an office, was a table, on which was placed some small black bottles containing different collarya, a case in which was a set of Luer's eye instruments, an old fashioned desk and several chairs. Next to this was a small waiting room. He also rented two very plain rooms from a tailor on Johannesstrasse, which he fitted up with beds and dark curtains, to have those upon whom he operated stay in.

This was the modest beginning of Graefe's clinic, which in less than ten years was attended by people from all over the civilized globe. His first patient was a mild case of keratitis sent him by a friendly colleague. His first two operations, one a cataract extraction upon an old beneficiary, the other an iridectomy upon an organ grinder who had central opacities over both cornea, due to ophthalmia neonatorum, passed off successfully, but came near having a tragical ending in both cases.

The subject of the extraction developed delirium tremens on the second night after the extraction. He got out of bed, tore off his bandages, and beat the organ-grinder, who was lying in the next bed, over the head and face. Notwithstanding vigorous treatment the drunkard died the next evening. At the autopsy the corneal flaps were shown to be adherent and the healing process to have been progressing nicely.

The night episode passed off without further damage to the organ-grinder. By means of the artificial pupil he was enabled for the first time in his life to go about without being led. The fear of that night, however, made it impossible to get him to consent to an operation on the other eye.

A notice in the Berlin papers, that the needy having eye troubles could get free treatment at Dr. von Graefe's on Behrenstrasse, first brought only the poorest class. Later, however, a somewhat better class of patients came. In less than a year both the profession and the wealthy inhabitants recognizing his ability, his practice became so large that he had to exchange his small dwelling for a larger one, "Unter den Linden." Somewhat later he rented the house No. 46 Karlstrasse for his polyclinic.

At first Graefe used the material of the Military Hospital and the Blind Asylum for his operations, but it was not long before his own polyclinic and private practice yielded him ample material.

Not only did Graefe's practice rapidly increase, but he also soon collected around him many students, to whom he taught ophthalmology. He soon found it necessary to have assistants. Among those who served him in the capacity were Liebreich, Alfred Graefe, Schweiger, Michaelis, Schelske, Leber and many others who have since risen to be noted ophthalmologists.

Graefe first heard of the discovery of the ophthalmoscope while in Vienna. Helmholtz was kind enough to send him one of the first of these instruments finished at Königsberg. Graefe immediately began practicing with it, using all his patients and also the colleagues who assisted him for this purpose. When he saw for the first time not only the red reflex, but also made out the different parts of the fundus, his eyes sparkled, his cheeks became flushed, and he enthusiastically exclaimed: "Helmholtz has opened a new world to us; how much there will be to discover therein." He was one of the first to put this valuable instrument into clinical use and much that he accomplished is due to it.

In the autumn of 1852 Graefe was appointed a "Private Instructor" at the University of Berlin. At the same time his treatise "Upon the Workings of the Eye Muscles" appeared. In 1857 he was appointed associate professor and in 1866 professor of ophthalmology at this institution.

His fame quickly spread and soon sufferers from eye diseases and physicians wishing to take up ophthalmology came, first from the

Continent and then from all parts of the civilized globe, either to get relief on the one hand, or to profit by his brilliant lectures and clinics on the other.

Soon after his appointment at the University he read before the Berlin Society of Scientific Medicine a paper upon "The Choosing of the Suitable Strabismus Operation." In this he took exception to the then prevailing disfavor at the operation.

In 1854 he founded the Archives of Ophthalmology, which to this day are known as Graefe's Archives. The first contained mostly his own writings. Of the 480 pages there were but 86 which were not his own work. His most important articles in this volume were: "Double Vision after Strabismus Operation and Incongruence of the Retina," "Diphtheritic Conjunctivitis and the Applications of Caustics in Acute Inflammations," and "Contributions upon the Physiology and Pathology of the Oblique Eye Muscles." He soon persuaded Arlt and Dorders to enter upon the editorship of this work with him.

At his clinics, which were filled with physicians of all nationalities, he captivated his hearers not alone by the scientific import of his talks, but also by his manner of delivery and his personal magnetism.

Graefe did not become one-sided and throw all his energies into the field of ophthalmology, but followed with the greatest interest the advances in all the branches of medicine.

In the whole sphere of ophthalmology there is hardly a condition the accepted knowledge of which he did not either entirely change or enrich.

He was the first to recognize that the gradual loss of vision and blindness in brain troubles were due to an optic neuritis and not to a paralysis of the optic nerve. He explained the relationship between brain tumor and choked disk. His recognizing of the embolus of the artery centralis retina, which causes sudden one-sided blindness, was a brilliant demonstration of his keenness of diagnosis. His services in the field of glaucoma are undying. The operation of iridectomy in this condition, which saves many otherwise doomed eyes, is one of the greatest benefits to mankind. We can also thank him for the now

universally used method of cataract operation by means of the modified linear extraction. This operation has lowered the loss of eyes from ten per cent to from two to three per cent. He was the first to do tenotomy of the external rectus muscle in myopia with an insufficiency of the internal rectus. He was the first to make a systematic examination of the narrowing of the field of vision in ambliopia. He did much to advance the knowledge of the pathological anatomy of the eye.

Besides contributing to the medical journals many interesting and instructive articles and teaching many physicians his specialty, he also took an important part in the proceedings of the medical societies and congresses.

It is with much pride that many of our most noted ophthalmologists of the present day point to having been pupils of this great man.

He exerted the same influence upon ophthalmology as did his famous teacher, Virchow, upon medicine.

In May, 1862, Graefe married Countess Anna Knuth, of Denmark. He had five children, of whom a son and two daughters survived him.

Already in the latter part of the '50's Graefe began to fail. He had hemorrhages from the lung, which were followed by numerous attacks of pleuritis. In 1861, while at Baden Baden, he had one of these attacks, which his doctors thought would be his end. He, however, recovered and returned to Berlin to work with renewed energy. This trouble recurred yearly. Nevertheless, he gave himself no rest and worked incessantly. He, however, succumbed at last on July 20, 1870, at the early age of forty-two.

At Berlin on May 22, 1882, a monument was unveiled to his memory, at which his former pupil and assistant, Schweiger, delivered the oration.

His biographer, Michaelis, sums up his life in the following words: "Ever creating new ideas, being at the head of every advance in his science, working incessantly, unmindful whether filling up fundamental details or verifying already obtained results or amplifying the same. This is a portrait of his short but useful career."

A CASE OF SMALL-POX IN UTERO.

BY DR. H. W. B. ROWE, '01, AND E. B. FRIEDENWALD, '03.

Mrs. S., white, a primapara, aged 19 years, menstruated last in November, 1901.

She was vaccinated at the beginning of April, 1902, and in about a week, when the vaccination had just commenced to take, the first symptoms of small-pox appeared.

The attack was a very light one, lasting about ten days. The patient was not forced to go to bed nor did it result in many scars. There are, however, some distinct pits upon the face and body.

I did not attend the case at this time. The case was seen, however, by Drs. Fulton and Noble, besides the attending physician, and was diagnosed as small-pox.

No foetal movements were perceptible after the attack, although patient had noticed them before. I was called to attend the patient in labor and saw her for the first time on the morning of May 21, 1902. She was apparently five or six months pregnant. After getting the history of absence of foetal movements, and not being able to elicit foetal heart sounds, upon examination a diagnosis of probable dead foetus was made. This was confirmed by a vaginal examination which gave a presenting macerated head. About noon the os was sufficiently dilated to justify a mechanical means of rupture of the membranes. This was resorted to. A rapid delivery followed, the child and placenta being delivered in less than half an hour. The mother made a good recovery.

From its size the foetus appeared to be of about five months' development. Although macerated and seeming to have been dead several weeks, it was in a good state of preservation. The important part of the history is that the foetus bore signs of having had small-pox in utero. The trunk, scalp and extremities were covered with scars or pits varying in size from a buckshot to a ten-cent piece.

Pregnancy does not predispose to small-pox, but the disease is apt to assume a severer type in this condition.

Small-pox has been observed as early as the fourth month of embryonic life.

Hirst states that in the majority of cases the fœtus is not affected, but that sometimes the mother having only varioloid the child may be born with the signs of small-pox on it. John MacCombie, of the Southeastern Small-pox Hospital of London, does not consider the liability of the fœtus to small-pox great. He says the ratio of liability increases with the age of the fœtus. He reports six infants born of variolous mothers, only one having small-pox at birth.

Nothnagel's Encyclopedia states that a pregnant woman having small-pox generally bears children with the marks of small-pox on them. It has also been reported of twins that either one or both may be affected.

In some cases the fœtus can acquire immunity from small-pox by vaccination of the mother, but as a rule this does not occur. Sometimes a mother not having the disease may bear a child having the mark of the disease. In some of these cases the mother may have had an attack so slight that it was not noticeable.

An interesting case is reported of a woman bearing a child with the marks of small-pox on it. She had had small-pox previous to this and nursed a case of the disease when far advanced in pregnancy. This child was afterwards inoculated without taking the disease.

Curschmann cites an interesting case. A woman servant aged 22 years in fifth month of pregnancy suffered from varioloid from November 20 to December 12, 1870. On December 28 fœtal movements suddenly ceased. On the 31st a five to six months' child, evidently already some days dead, was born. It presented a well formed small-pox rash in the stage of suppuration, covering the whole body. The appearances were such as to place the time of death (on December 28) somewhere between the sixth and eighth day of the disease.

TETANY.—REPORT OF A CASE.

By G. L. VIEWIG, '02.

Tetany, a condition characterized by tonic muscular spasm, which usually affects the muscles of the hands and feet. This condition, according to Holt, is very rare in this country, until 1895 there being only 50 cases reported.

As to the etiology of tetany, quite a number of causes are reported by different authors. It is not the object of this article to go into detail as to the various causes, treatment, etc., of tetany, as a full description can be found in the various text-books on children.

The history of this case is: Family history—Mother and father both living and in good health, both, however, being of a very nervous temperament.

Personal history—Age, 22 months old; sex, male; child well nourished. About ten days previous child suffered from a slight attack of ileocolitis, from which he entirely recovered. On January 18, 1903, child was suffering from a severe cold, and that night developed a spasmodic laryngitis, for which an antispasmodic was prescribed. About 11 o'clock of same evening mother noticed a peculiar cramped condition of the hands and feet. On being called found the child suffering with tetany. The fingers were flexed at the metacarpal-phalangeal joint, phalanges extended and thumbs abducted under fingers, touching the palmar surface of little finger, wrist flexed. The phalanges of the toes were flexed at the first joint and the second and third rows were extended, the plantar surface of the foot being strongly arched. The patient also suffered with a spasmodic contraction of the compressed urethra and its urine had to be drawn four times.

The spasm of the hands and feet was almost continuous, being aggravated still more by each attack of spasm of larynx. During the first twenty-four hours there was little or no pain, but after that the child seemed very irritable and would cry out when any attempt was made to examine the affected parts. Patient carried no fever and was conscious at all times. The duration of this condition lasted one week.

The treatment of this case was potassium and sodium bromides, with tincture gelsemium internally, while the hands and feet were bathed in hot mustard water and massaged. The last two days of the treatment was given to the galvanic current.

BEHRING'S VIEW OF THE IDENTITY OF TUBERCULOSIS OF HUMAN AND BOVINE ORIGIN.

In his experiments on the immunity in regard to tuberculosis some authors attempted to give Behring's view as being the same as that of Koch. That is, that he believed in the separate identity of the bacillus of bovine and human tuberculosis and that man could not contract the disease from animals. In a recent article in the *Wiener klinische Wochenschrift* Behring opposes this idea and states that he believes

that the opinion of the innocuity of bovine tuberculosis for human beings is founded on facts that are in themselves questionable.

In regard to the frequency of primary tuberculosis of the intestines, which Koch insists is rare, he states that he (Behring) is of the opinion that it is relatively frequent. Heller states that it occurs in 37 per cent of the cases in infants. That it is rare in adults cannot be questioned, but, on the other hand, when one reflects a moment, one will note, also, that even in individuals with tuberculosis of the lungs, who are constantly swallowing saliva containing the tubercle bacilli intestinal lesions are also rare. No one would however say that these bacilli were not pathogenic for man. There must be another factor in the question besides the virulence and the port of entry.

Leaving aside the question of the influence of pregnancy, lactation, food, intercurrent diseases and the like, the exact effect of which has been ascertained with reasonable accuracy, Behring draws attention to the less known fact of the imperfect development of the intestinal mucous membrane of the newly born. The membrane is not absolutely continuous and albuminoid antitoxins are absorbed as readily when introduced into the stomach or rectum as they are by injecting them under the skin. In adults the same antitoxins in the stomach or rectum are without effect. Bacteria introduced with the food may also find an easy foothold in the intestine of the newly born while in adults they may be perfectly harmless.

Young calves not infrequently contract tuberculosis of the intestines and do not show any signs of the disease. They do, however, react to tuberculin and show lesions at autopsy. No doubt many of them get well while in others the infection spreads to the other organs and is finally recognized as pulmonary tuberculosis.

Behring does not believe that there exists any great danger to adults either from meat or butter obtained from infected animals. He does think, however, that there does exist a very grave danger for infants who are fed on milk containing tubercle bacilli whether of bovine or human sources.

ON THE EDUCATIONAL VALUE OF THE MEDICAL SOCIETY.

The above was the subject of an address by Dr. William Osler at the centennial meeting of the New Haven Medical Association held on January the sixth, this year. It is published in the April number of the Yale Medical Journal, and we recommend all who have access to the Journal to read it. If they are interested in medical society work we would suggest that they send for it and read it to their brethren.

Like all of Dr. Osler's writings it is characterized by breadth of conception, and accurate knowledge of minutiae coupled with a literary style which has seldom, if ever, been excelled by a medical writer. The value of the medical society as an educator of the profession and its various uses are discussed. We cannot abstract it, for one would miss the charm of the address, and be left with the barren facts. Some of the thoughts however may be given.

"There are many problems and difficulties in the education of a medical student, but they are not more difficult than the question of the continuous education of the general practitioner. Over the one we have some control, over the other, none. The university and the State Board make it certain that the one has a minimum at least, of professional knowledge, but who can be certain of the state of that knowledge of the other in five or ten years from the date of his graduation? The specialist may be trusted to take care of himself, the conditions of his existence demand that he shall be abreast of the times; but the family doctor—the private in our great army—the essential factor in the battle, should be carefully nurtured by the schools and carefully guarded by the public. Humanly speaking, with him are the issues of life and death, since upon him falls the grievous responsibility in those terrible emergencies which bring darkness and despair to so many households. No class of men needs to call to mind more often the wise comment of Plato that education is a life-long business. The difficulties are partly adherent to the subject, partly have to do with the individual and his weakness. The problems of disease are more complicated and difficult than any others with which the trained mind had to grapple; the conditions in any given case may be unlike those in any other; each case, indeed, may have its own problem. Law, constantly looking back, has its forms and procedures, its precedents and practices. Once grasped the certainties of divinity make its study a delight and its practice a pastime; but who can tell of the uncertainties of medicine as an art? The science on which it is based is accurate and definite enough; the physics of a man's circulation are the physics of the water-works of the town in which he lives, but once out of gear, you cannot apply the same rules for the repair of one as of the other. Variability is the law of life, and as no two faces are alike, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease. This is the fundamental difficulty in the education of the physician, and the one which he may never grasp, or he takes so tenderly that it hurts, instead of boldly accepting the axiom of Bishop Butler, more true of medicine than of any other profession: 'Probability is the guide of life.'

* * * * *

WILLIAM S. GARDNER, M. D., EDITOR,
1012 McCulloh Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER,
Mt. Washington.
Telephone, C. & P., Tuxedo, 984.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

SCARLET FEVER.

There are quite a number of recent publications of interest concerning scarlet fever. It would be beyond our scope to go over them all critically. A passing glance at one or two of them, however, may not be amiss.

The early diagnosis is of especial interest. The initial vomiting, present in about eighty per cent of the cases, is of no great value, occurring as it does at the outset of many other conditions. The throat symptoms may not be very marked. But when the disease is suspected, if there is a punctate eruption in the axilla and groin, a redness of the tonsils and a punctate eruption on the palate, the diagnosis is reasonably certain, even in the absence of a general eruption. McCollum, of Boston, points out another sign on which he places great reliance. This is the early enlargement and reddening of the fungiform papillæ of the tongue. They are apt to be along the borders and near the point of the tongue and are easily distinguished from the filiform papillæ. They may look like cayenne pepper scattered over the tongue, or they may be much larger but without any very especial coloring. The change is due to infiltration of leucocytes as well as vasomotor disturbance. The strawberry tongue is but an advanced stage of this condition. This hypertrophy of the fungiform papillæ is the earliest change noted and

lasts some five or six weeks. The papillæ of the tongue may be enlarged in other conditions, gripe, for example, but in this and other diseases the fungiform are not especially singled out and are not higher than the filiform and are not of a different color.

In this connection we may call to mind McCollum's late sign of scarlet fever, i. e. the white line seen on the finger-nail at the juncture with the pulp of the finger. This comes on as early as the fifth day and is always present. When the desquamation is imperfect it is of value in making a diagnosis on the late cases. It is of especial interest in connection with dispensary work.

Along therapeutic lines there is a recent contribution based on the work of Finsen, who has used successfully the red light rays in the prevention of pitting in small-pox. M. E. Schoull, of Tunis, has isolated his scarlet fever patients in rooms with red light. The windows are curtained with red stuffs and the lights in the wards have red shades. Not a ray of any other colored light is allowed to enter. The patients remain in this room four or five days or during the period of the eruption. In six cases treated by this method there was no desquamation in four, in two there was slight desquamation, but one of these was not treated until the third day, while the other was only in the red light forty-eight hours.

Polievktov, in Moscow, has recently published the report of one hundred and ten cases of scarlet fever treated by Taube's method. This method, suggested in 1877, and used especially by Heubner, of Berlin, consists of injecting into the throat three to five per cent solutions of carbolic acid. The injections are made with a long-needed syringe, about a cubic centimetre being given at a dose in several punctures. Ten or a dozen doses generally suffice. If urinary symptoms make their appearance the treatment is stopped.

The mortality in his cases was sixteen per cent and covered four years with epidemics of varying severity. The author draws no definite conclusions but states that there was an amelioration of the symptoms and that there was an absence of suppurating glands, so common an accompaniment of the severe anginas. He recommends that the treatment be commenced as soon as the diagnosis is made.

The question of the relation of the streptococcus to the disease is always one of great interest. Recent contributions have been made by Aronson, of Berlin, —————, of Montreal, and Moser, of Vienna.

The streptococcus has been known to be closely associated with scarlet fever since 1885. Some authorities think that the disease is due to a streptococcus. Among these may be mentioned Klein, V. Babes, D'Espine, Soerensen, W. Class, Baginsky, Sommerfeld, Hlava and others. Others place the streptococcus as a secondary infection. Among these are Crooke, A. Fraenkel, Raskin, Heubner, Marmorek, Slawyk and many others.

Moser, working in Escherich's clinic, has published his article recently in the *Jahrbuch für Kinderheilkunde*. He thinks that the streptococcus that he has found in the cases of scarlet fever is a distinct variety, and while he does not claim that it is the cause of scarlet fever he is inclined to believe that it is. He has produced a serum, obtained by using the streptococci directly from the patients without passing them through other animals. With this serum he has had results that are very gratifying. His earlier cases did not do as well as his later, as they were all very severe cases and the dosage was not sufficiently large. Taken all in all, however, his report is the best that has yet been published on this important question. In the limited space we cannot give an abstract of his cases, which number over six hundred. Suffice it to say that there has been a lowering of the mortality and an amelioration of the symptoms.

R.

POST-GRADUATE COURSES.

The prospect of a good attendance at the spring post-graduate courses is very flattering. The work is arranged especially to meet the requirements of the general practitioner who wishes to broaden his work by comparing his own methods of practice with modern hospital practice. The work to be gone over this year will be similar to that done last year, but the schedule has been very much improved and there will be no conflicting hours. Each one attending will be able to follow all the clinical work, both medical and surgical.

SPECIAL ALUMNI NOTICE.

The regular annual meeting of the Alumni Association will be held at the College, Monday, April 27, at 8 P. M. The annual address will be delivered by Dr. Francis J. Snyder, '87, of York, Pa.

Immediately after this meeting the annual banquet will be held at the Hotel Rennert. The dinner at the same place last year was one of the most satisfactory in every respect that the Association has ever had. There is every reason to believe that this year it will be equally successful. Tickets can be had on application to Dr. Beck, Greenmount avenue and Chase street; Dr. Sanger, 525 North Charles street, or Dr. Rosenthal, 211 West Franklin street.

The commencement exercises will be held at Ford's Opera House, Thursday, April 30, at 12 o'clock noon. Hon. Olin Bryan will deliver the oration.

Personal Notes

DR. J. C. McALLISTER, '89, of Ridgway, Pa., will go to Europe in April to do post-graduate work.

DR. S. WALTER WOODYARD, '91, is secretary and treasurer of the Greene County (Tenn.) Medical Society.

DR. U. P. WHITE, '94, who has an extensive practice at Athens, Ohio, will attend the commencement and remain for the post-graduate course.

DR. T. G. HAMRECK, '95, is located at Caroleen, N. C., where he has been very successful. Three years ago he took a post-graduate course in New York.

DR. C. BROTEMARKLE, '81, has given up his practice and is located in Cumberland, Md., where he is secretary and treasurer for a large coal and coke company.

Deaths.

DR. JOSEPH CHARLES, '81, died at Weston, W. Va., Dec. 15, 1902.

DR. BARTUS TREW, '90, died in Baltimore, Dec. 12, 1902, of suppurative endocarditis.

DR. W. FRANK ROSS, '81, died of Bright's disease at Knoxville, Tenn., January 6, 1903.

DR. THOMAS A. COUNCELL, '94, of Easton, Md., died at the City Hospital, Baltimore, of Bright's disease, February 18, 1903.

DR. WILLIAM FLOOD SMITH, '89, died of pneumonia after an illness of six days at the Union Protestant Infirmary, Baltimore, April 15, 1903.

DR. WILLIAM T. RIDDLEMOSER, '84, died at his home, Smithsburg, Md., February 18, 1903, of tubercular meningitis. He leaves a widow and one son, aged 12 years

SOLVAY, N. Y., December 4, 1902.

DR. CHAS. E. BRACK, Baltimore, Md.

My Dear Doctor.—Enclosed find P. O. order for one dollar (\$1.00) for the ALUMNI JOURNAL, ending April, 1903. I take great pleasure in reading the JOURNAL, as I see in its columns many things that take me back to my college days and keep me in touch with many things that I would otherwise remain in ignorance of. As you no doubt are always glad to know of the success of any graduate of the good old College of P. & S., I will say that since my graduation in 1893 I have had my ups and downs, and have been rewarded with success. I have a large private practice in Syracuse and Solvay, a suburban town of 4000 inhabitants; am examining physician for the following insurance companies: N. Y. Life, Mutual Life of New York, Solvay Mutual Benefit Society, Modern Woodmen of America, Independent Order of Foresters, Maccabees; am also a member of Syracuse Academy of Medicine, and Health Physician to village of Solvay. I have not had the pleasure of

visiting the city of Baltimore since my graduation, but hope some time in the near future to visit the scenes of my college days. My sincere wish is that the JOURNAL will continue to grow and prosper. Hoping to hear from you and all the "boys" through columns of the JOURNAL, I remain,

Yours most sincerely and respectfully,

DR. W. P. KANAR,
517 Milton Ave., Solvay, N. Y.

AKRON, OHIO, Oct. 27, 1902.

JOURNAL OF ALUMNI ASSOCIATION,

College of P. & S., Baltimore, Md.

I write to inform you of the death of Dr. Eugene G. Carpenter, Class of 1884, who was Supt. of the Columbus State Hospital at the time of his death. The College of Physicians and Surgeons was honored by the work of Dr. Carpenter, who had become recognized as the leading alienist in Ohio. His opinion was frequently sought by the courts, as well as by individuals in many parts of Ohio. He had served more than four years as Supt. of the Hospital and five years as assistant to the late Dr. Jamin Strong, of the Cleveland State Hospital. After leaving the Cleveland Hospital he spent two years in Europe in special study of mental and nervous diseases. The Doctor was but 45 years of age, and died after two days' illness from paralysis. He leaves a wife and one son, five years of age.

Very truly yours,

W. W. LEONARD, '83.

LE ROY, LA.

DR. CHAS. E. BRACK, Balto., Md.

Dear Doctor.—I herewith send you one dollar to pay my subscription to the JOURNAL till April next year. Please do not fail to send the JOURNAL to me regularly, as it seems like an old friend entering my office every time I receive it.

I am of the class of '89, and have been practicing in this county ever since. I am the only C. P. & S. graduate in this county, but in the next county there are two others, Dr. J. F. Mouton, class of '89, and

Dr. Geo. Strohmer, class of '91, and from what I hear of them, we are all holding our own.

Sincerely yours,

J. T. ABSHIRE.

ACME, W. VA., February, 1903.

DR. WM. S. GARDNER, Baltimore, Md.

Dear Doctor.—I enclose one year's subscription to the ALUMNI JOURNAL. Each issue awakens within me memories fresh of college days, the happiest of one's life. But the last number of the JOURNAL was a sad one. I am sure I voice many others in saying that to hear of the death of one under whose voice we sat, so anxiously listening to his teachings, is as affecting as to hear of the death of a very near relative. The representative likeness of Professor Friedenwald in the JOURNAL is a noble one, and a noble specimen of mankind. I enjoy the personals of the JOURNAL, especially the 87's. With best wishes for our Alma Mater, I am,

Yours sincerely,

L. M. CAMPBELL, '87.

FREEBURG, PENNA., 1903.

Dear Sir.—I am of the class of 1881 and was the only Tool in that class, and am always glad to hear of my classmates and their whereabouts. We are all got pretty frosty since we left Baltimore in March, 1881. I served in Pennsylvania Legislature four years and have been a pension examiner since 1889. All our classmates or College of Physicians and Surgeons of Balto., Md., boys don't take back seats in our central part of Pennsylvania. So you can see we are all on top. Morand Rothrock, '81, E. W. Tool, '81, J. E. Bogar, '92, W. W. Longacre, '93, J. W. Wagner, '80, J. W. Sheip, '82, L. E. Wolfe, '91, are all here in Snyder Co., Pa., not fifteen miles apart, and are the leading physicians in the county.

Hoping to hear from more of our classmates, I am

Yours truly,

E. W. TOOL, '81.

FREMONT, N. C., 1903.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—You will find enclosed two dollars for my subscription to ALUMNI JOURNAL. I am always glad to get the JOURNAL and hear from the boys. I was sorry to hear of the death of Professor Friedenwald. I graduated in the class of '94 and came to this place in the following August and have been here ever since, and have had a very satisfactory practice. I am examiner for several of the leading life insurance companies and am local surgeon for this point of the Atlantic Coast Line Railroad Company.

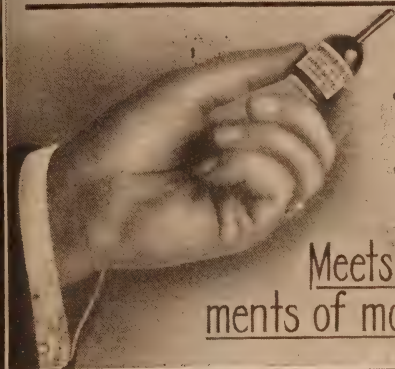
Dr. Geo. A. Hood, '95, was located near me at Kenly. He is so badly afflicted with rheumatism that he had to give up his practice two or three years ago. He was having a very fine practice until his health gave way a few years ago. He is now druggist for the Benson Drug Company at Benson, N. C.

I may go to Baltimore some time during April or May. If I do I will go and take a look at P. & S., of course.

Very truly,

W. T. TURLINGTON, '94.

Parke, Davis & Co's ANTIDIPHThERITIC SERUM



*Supplied in hermetically
sealed glass bulbs.
Every lot physiologically
and bacteriologically
tested.*

Meets the most rigid require-
ments of modern medical practice.

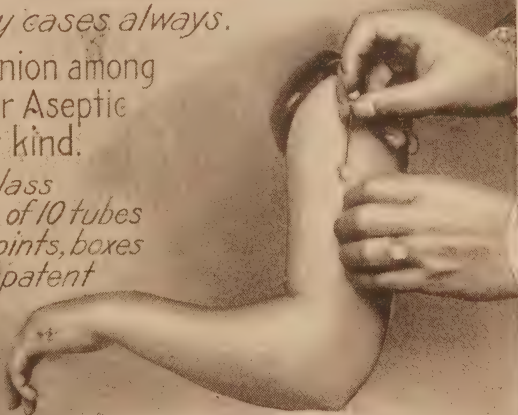
THE IDEAL VACCINE

Is the Vaccine that
PRODUCES VACCINIA ONLY

and in primary cases always.

The consensus of opinion among
physicians is that our Aseptic
Vaccine is just that kind.

*Supplied in sealed glass
capillary tubes, cases of 10 tubes
and 3 tubes; also in points, boxes
of 10; each in a Lees patent
breakable tube.*



PARKE, DAVIS & COMPANY.

LABORATORIES:
DETROIT, MICH., U.S.A. WALKERVILLE, ONT., CAN. HOUNSLOW, ENG.

BRANCH HOUSES
NEW YORK, KANSAS CITY, BALTIMORE, NEW ORLEANS, CHICAGO, MINNEAPOLIS, MEM-
PHIS, INDIANAPOLIS, BOSTON, U.S.A. LONDON, ENG. MONTREAL, QUE., SYDNEY, N.S.W.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, N. Y., Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S.	Ohio.	B. B. DONALDSON, D. D. S.	D. C.
E. PARMLY BROWN, D. D. S.	N. Y.	H. A. PARR, D. D. S.	N. Y.
A. L. NORTHPROP, D. D. S.	N. Y.	J. EMOBY SCOTT, D. D. S.	Md.
E. L. HUNTER, D. D. S.	N. C.	C. L. ALEXANDER, D. D. S.	N. C.
W. W. WALKER, D. D. S.	N. Y.	M. M. MAINE, D. D. S.	Conn.
OSCAR ADELBURG, D. D. S.	N. J.	J. W. DAVID, D. D. S.	Texas.
G. MARSHALL SMITH, D. D. S.	Md.	A. C. BREWER, D. D. S.	Md.
C. M. GINGRICH, D. D. S., Resident.	Md.	J. ROACH, D. D. S.	Md.
J. HALL MOORE, D. D. S.	Va.		

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

W. W. DUNBRACCO, D. D. S.	J. K. BURGESS, D. D. S.	J. C. SUTHERLAND, D. D. S.
GEO. V. MILHOLLAND, D. D. S.	CHAS. THEBERATH, D. D. S.	
L. M. PARSONS, D. D. S.	HARRY E. KELSEY, D. D. S.	C. H. CARSON, D. D. S.
H. M. LEVER, D. D. S.	C. S. GORE, D. D. S.	L. F. PALMER, D. D. S.
C. R. STEWART, D. D. S.	L. D. CORIELL, D. D. S.	
H. H. HAYDEN, M. D., Demonstrator of Anatomy.		
C. F. BLAKE, M. D., Demonstrator of Anatomy.		

The Sixty-Third Annual Session will commence on the 1st of October, 1902, and continue until May, 1903.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.

MULFORD'S GLYCERINIZED VACCINE

"ALWAYS TAKES"

Yields **100%** SUCCESSFUL VAC-
CINATIONS IN
PRIMARY CASES

Supplied in complete outfit containing
scarifier, bulb for expelling lymph from
capillary tube and 10 tubes **\$1.00**
of Glycerinized Vaccine . . .



Literature mailed upon request
Supplied by all reliable druggists



H. K. MULFORD COMPANY
—CHEMISTS—

Philadelphia New York Chicago

College of Physicians and Surgeons OF BALTIMORE.

— FACULTY —

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- AARON FRIEDENWALD, M. D.,
Professor of Diseases of the Eye and Ear.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Medical Jurisprudence and Director of Pasteur Institute.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, A. B., M. D.,
Professor of Obstetrics.
- WM. ROYAL STOKES, M. D.,
Professor of Pathology and Bacteriology.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- O. HAMPSON JONES, M.B., C.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- HARRY FRIEDENWALD, A. B., M. D.,
Associate Professor of Diseases of the Eye and Ear.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MOCLEARY, M. D.,
Associate Professor of Histology and Pathology.
- CHARLES E. BRACK, M. D.,
Associate Professor of Obstetrics.
- JOHN RUHRÄH, M. D.,
Clinical Professor of Diseases of Children.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Clinical Professor of Diseases of the Rectum.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MOGLANNAN, M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- THOMAS B. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- MELVIN ROSENTHAL, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- ALBERTUS COTTON, M. D.,
Associate Professor of Orthopedic Surgery.
- ARCHIBALD C. HARRISON, M. D.,
Demonstrator of Anatomy.
- GLENN M. LITSINGER, M. D.,
Demonstrator of Obstetrics.
- A. SAMUELS, M. D.,
Demonstrator of Chemistry.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- JOHN MASON KNOX, JR., M. D.,
Demonstrator of Pathology and Physical Diagnosis.
- CHARLES B. CANBY, M. D.,
Demonstrator of Pathology.
- OTTO C. GLASER, A. B.,
Demonstrator of Embryology.
- L. K. HIRSHBERG, A. B., M. D.,
Demonstrator of Bacteriology and Assistant in Neurology.
- O. W. G. ROHREK, M. D.,
Demonstrator of Pathology and Resident Pathologist.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. SAMUELS, M. D.,
Assistant in Genito-Urinary Surgery.
- OTTO SCHAEFER, M. D.,
Assistant in Eye and Ear Diseases.
- HERMAN WESTPHAL, M. D.,
Assistant in Surgery.
- W. EDWARD MAGRUDER, M. D.,
Assistant in Diseases of Children.
- L. J. ROSENTHAL, M. D.,
Assistant in Diseases of Stomach.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, Md.

Table of Contents Page III.

Issued Quarterly

Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS
BALTIMORE.

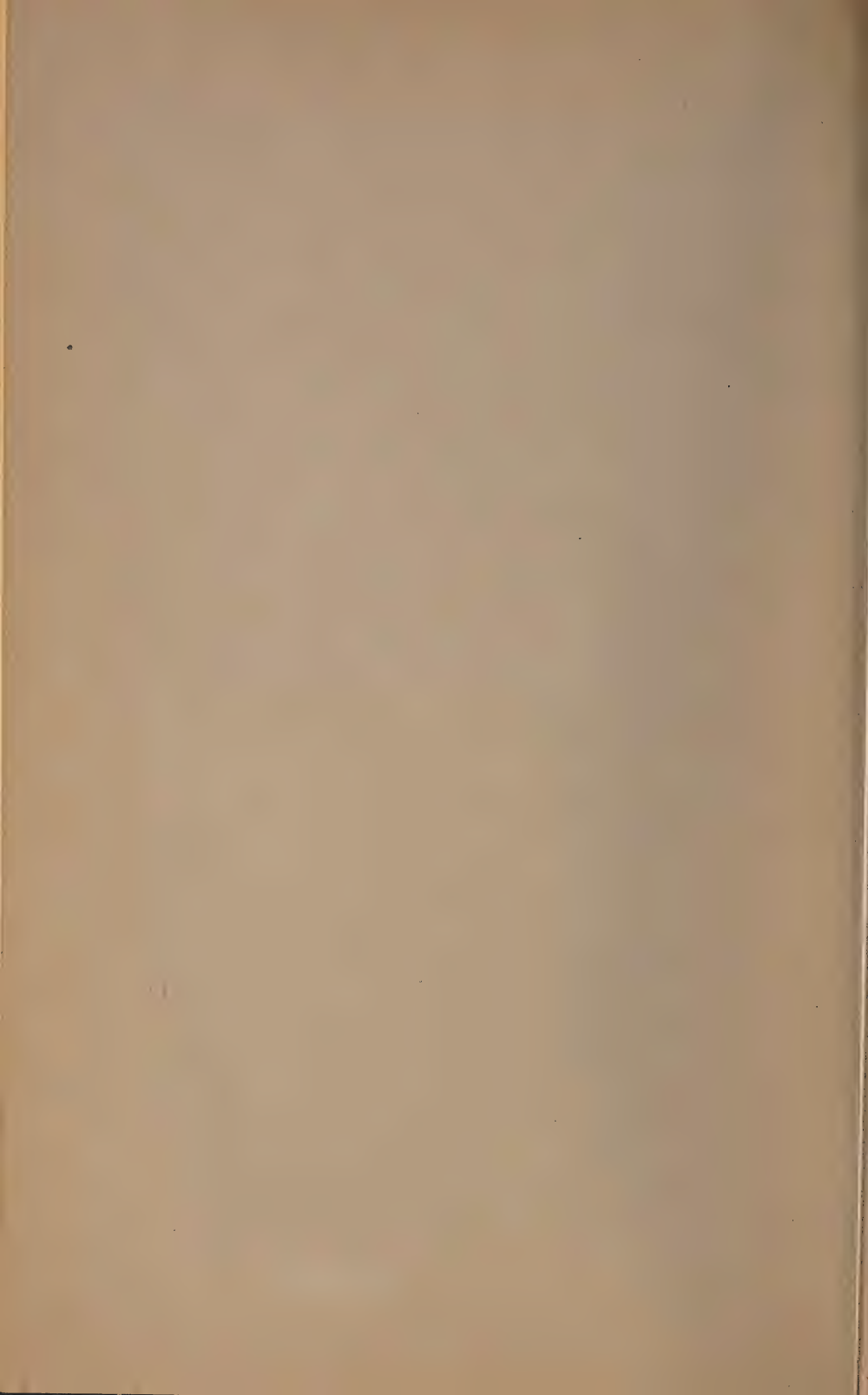
Vol. VI

No. 2

JULY, 1903

PUBLISHED AT

Baltimore and Eutaw Sts. Baltimore, Md.



The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—PROF. THOS. S. LATIMER, M. D.

Chief of the Laboratory.—PROF. N. G. KEIRLE, A. M., M. D.

Asst. Chief of the Laboratory.—ASSOCIATE PROF. JULIUS FRIEDENWALD, A. M., M. D.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

DR. RICHARD F. GUNDRY,

CATONSVILLE, MD.

REFERENCES:

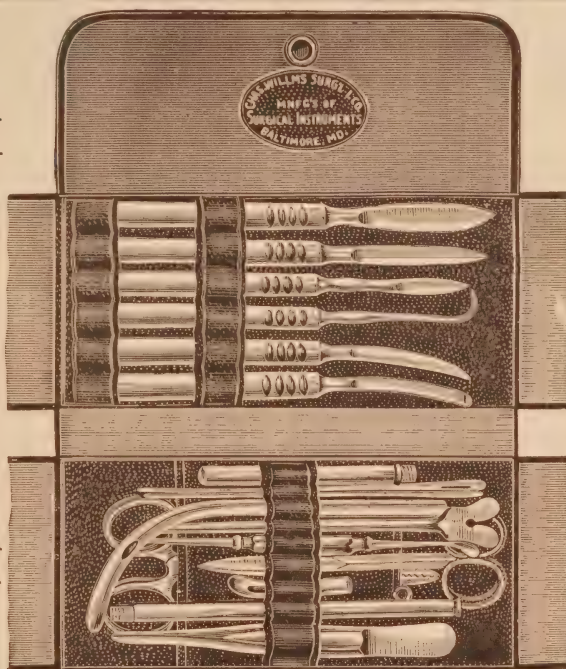
Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

Table of Contents.

	PAGE
The Treatment of Puerperal Eclampsia, with Report of Cases. ROBERT PERCY SMITH,	33
The Bacterial Flora of Salt Water Fish. ROSS ANDERSON and WALTER T. HASLER,	41
Case of Double Vagina, One Canal Lying Above the Other. DR. IRVIN HARDY	44
Wounds of the Thorax. DR. ISAAC R. TRIMBLE,	45
Editorial,	49
Personal Notes,	iv, 61
Correspondence,	63

"OUR LEADER."

Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.



All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.

THE CHAS. WILLMS SURGICAL INSTRUMENT CO.,
MANUFACTURERS AND IMPORTERS,
300 N. HOWARD STREET, - - - BALTIMORE, MD.
 PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES,

Personal Notes.

DR. GEORGE L. FAUCETT, '03, has opened an office at Roanoke, Alabama.

DR. W. C. HORTON, '97, of Wakefield, N. C., spent the month of May taking special courses here and in New York.

DR. L. A. GRIFFITH, '78, of Upper Marlboro, Prince George's County, was appointed one of the State Board of Examiners of Maryland.

DR. JAMES A. RIEDY, '02, who was one of the Resident Physicians at the City Hospital during the past year, has struck a rich job at Fairmont, W. Va.

DR. ANDREW J. SAUER, '94, died at his home, 3042 O'Donnell Street, Baltimore, May 20, 1903. He was buried from St. Bridget's Church, May 23.

DR. C. F. BEVAN and DR. J. H. M. KNOX were the members of the Faculty who attended the American Medical Association meeting at New Orleans.

DOES EVERYTHING

that *syrups* of hypophosphites do, that is beneficial.

DOES NOTHING

that *syrups* of hypophosphites do, that is detrimental.

AROMATIC SOLUTION OF HYPOPHOSPHITES

Manufactured by
HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

Pint samples furnished upon application.

LAPACTIC PILLS

R

Aloin, S. & D.	gr. $\frac{1}{4}$
Strychninae,	gr. $\frac{1}{80}$
Extr. Belladonnae,	gr. $\frac{1}{8}$
Ipecacuanhae,	gr. $\frac{1}{8}$

M: et ft. Pil. No. 1.

The best and most reliable laxative pill ever offered the profession. The formula and name were originated by us, and because of the freedom of our Aloin from any resin of aloes or resinified aloes, due to our manufacturing it ourselves, Lapactic Pills never gripe and never fail. This cannot be said of the many substitutes offered the profession and the trade. Hence, please specify on your prescriptions and orders

SHARP & DOHME

CHICAGO.

BALTIMORE.

NEW YORK.

NEW ORLEANS.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

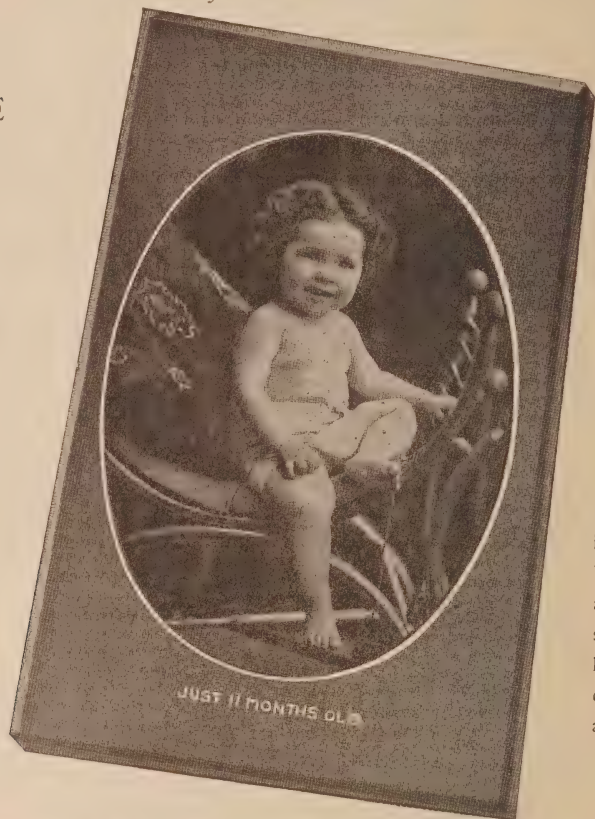
THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap has been used exclusively in this baby's bath from birth and her perfect skin and luxuriant hair excite wonderful interest and admiration.

AS A NUTRIENT SOAP
FOR THE SKIN . . .

Resinol Soap

IS WITHOUT A
. PARALLEL.

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.,
SYDNEY, N. S. W.
Agents for Australasia.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE TREATMENT OF PUERPERAL ECLAMPSIA, WITH REPORT OF CASES.¹

BY ROBERT PERCY SMITH, '91.

During the past few years much interesting discussion has arisen in medical circles on this very interesting subject, and the treatment has been so varied and far-reaching that I have been persuaded to relate my experience (small as it may seem), although success has attended each case.

Many physicians of much larger experience have reported more cases treated with varying success, but their mode of treatment has likewise been varied—casting about from one drug to another without any decided plan or a well-defined object in their administration.

Until the etiology of the disease is better understood than at present it will be impossible for us to treat this condition scientifically, and nothing remains for the physician but to meet the symptoms as they arise, and if possible remove them.

CASE 1.—April 30, 1900, I was called to Mrs. C. P., aged 20, primipara, previous health good, no symptom of any disease during her months of pregnancy excepting excessive nervousness, which, however, had been characteristic of the patient since childhood. Her

¹ Read before the Medical and Chirurgical Faculty of Maryland, April 30, 1903.

urine, which I analyzed once a month during pregnancy, was negative. I first saw the patient in the morning, labor having scarcely begun. I left to attend other duties, returning again about evening, and found some progress, the cervix having dilated about the size of a silver dollar.

I then arranged to remain with the patient during the night. She seemed rather to apprehend danger, as she was not satisfied for me to leave the room. To this, however, I attached no importance, knowing her usual nervous condition. Nothing of note occurred until a few minutes before midnight, when, immediately after a good uterine contraction, I noticed her apparently turn aside with eyes fixed upon the ceiling, then instantly all muscles became fixed and rigid and she lapsed into a most horrible convulsion.

Realizing at once what I had to deal with, I sent a messenger in haste for assistance to make an instrumental delivery, hoping that by emptying the uterus to end the eclampsia.

I then gave 15 grs. chloral and 30 grs. bromide in combination, watching also over my patient with chloroform in hand. In thirty minutes, and before the arrival of my assistant, another convulsion occurred.

Twenty minutes later we fully anæsthetized her and with forceps thoroughly removed a dead child. The uterus being thoroughly emptied we hoped the cause was removed and convulsions would cease. In this, however, we were disappointed, for in another half hour they returned with even greater force; 30 grs. chloral was then given, followed in 20 minutes with a full dose morphia; 10 minutes more and another convulsion appeared, then occurring almost regularly every half hour until they numbered seven.

Realizing then that we were powerless before such a hurricane and that each attack lessened the chances of my patient, I determined to try *veratrum viride* as a last resort, having read an article some years ago by Dr. Fordyce Barker in which he strongly advised it.

I accordingly gave 15 minims and repeated the dose in 20 minutes. Shortly after another convulsion occurred; again I gave 20 minims

and waited thirty minutes, when another and most fearful attack came on, so much so I thought the end had come.

Then, deciding my patient had as well die from the medicine as the disease, I gave a half teaspoonful of veratrum and repeated the dose in 15 minutes. This brought the pulse down from 146 to 62 per minute and ended the eclampsia completely. Her recovery was uneventful and complete without any other treatment whatsoever.

CASE 2.—Was called August 18, 1900, to Mary L. (colored), who had been in labor 48 hours. She had already had three severe convulsions. I at once gave chloroform and delivered her with instruments, emptying uterus completely. As soon as she regained consciousness convulsions again returned. I at once gave a half teaspoonful of veratrum viride and repeated the dose in 20 minutes. The pulse dropped in two hours from 138 to 68 and no untoward symptoms again occurred. Her recovery was complete and without special note.

CASE 3.—On the morning of May 25, 1902, was called hurriedly to see Mrs. B. P., aged 23 years, primipara. Having been engaged a few months previous to attend her at delivery, I had called twice monthly on her, at each visit procuring a sample of urine.

The analysis at each test had been absolutely negative and the health of the patient especially good. She never suffered headache in the slightest degree and lived out of doors as much as possible. Only the day before being called I saw her on the street. When I reached her bedside at 5 A. M. her husband informed me that he was aroused from sleep by the muscular contractions, only to find the wife unconscious. A few minutes after my arrival she had another convulsion without having gained consciousness. I used chloroform during the attack and called an assistant. We fully anæsthetized her and removed with instruments a dead child. Immediately upon recovery from the chloroform the convulsion's returned. I gave 20 minims of Norwood's tincture of veratrum viride by mouth. In fifteen minutes another convulsion occurred; five minutes later I gave a half teaspoonful of veratrum, at which time her pulse was 142 per minute. In an

hour her pulse quieted to 62 per minute and no more seizures occurred. Her recovery was speedy and without note.

CASE 4.—December 7, 1902, was called to see Mrs. J. W., aged 19 years, primipara, previous health good. Her husband informed me that he had found his wife unconscious upon his return from work. I had never seen the patient before, but was informed she was in the seventh month of pregnancy. The patient received a fall from a trolley car about a week previous, with no apparent damage except general soreness and stiffness of back and legs. Upon examination I found the cervix fully dilated and the head engaged in the pelvis. I concluded to use chloroform to control the convulsions and allow the uterus to empty itself, which occurred in about 15 minutes. No further symptoms of convulsion occurred for the next two hours that I remained with her.

About an hour after leaving she was again seized, and before I reached her had four severe attacks, the last one as I entered her room.

I at once gave tincture *veratrum viride* 30 minims by mouth and repeated the dose in a half hour. No further symptoms appeared and recovery was complete and only retarded by a mild lymphangitis occurring a few days after delivery.

I have here reported four cases occurring in my practice with recovery in each instance. Text-books do not give us any assistance or advice along this line, unless to advocate the use of morphia or chloral, perhaps both. Some writer may mention *veratrum* as being "lauded by some and dismiss it by saying "he has never used it and has no knowledge of its effect."

Some suggest emptying the uterus and giving pilocarpine to induce elimination from the skin. Unfortunately emptying of the uterus will not always control the convulsion and in pilocarpine we have a great depressant. Blood-letting is also advocated and is undoubtedly beneficial in some instances, but having the disadvantages of impoverishing the blood by making it more watery, it therefore does not compare with *veratrum*, whose action very much simulates venesection, by reducing a bounding pulse and lessening arterial tension. It does so,

however, not by the spilling of blood, but by diverting the blood supply and emptying the already over-distended arteries into the venous system, thereby avoiding prostration of patient and the antagonism of the family and friends who perchance are opposed to bleeding as being out-of-date practice.

At a meeting of the American Gynecological Society held in Baltimore in May, 1895, Dr. Thaddeus A. Reamy, of Cincinnati, read a paper on "Puerperal Eclampsia Treated by *Veratrum Viride*," in which he states "it is fully equal to blood-letting in the action on the circulation, does not leave the patient in such a weak condition, at the same time excites profuse diuresis and diaphoresis." He seems to have controlled eclampsia with smaller doses than one-half teaspoonful, but adds "half-drachm doses can be given with impunity, if patient is kept in a recumbent posture.

At this same meeting the President (Dr. Matthew D. Mann, of Buffalo) stated his high opinion of *veratrum* in this condition, but had never used it in such large doses. He added "he felt sure he had saved several lives by its use, and as he had recently learned that it was so rapidly eliminated that large doses could be given without much danger, he intended in the future to push its administration even more boldly should circumstances seem to warrant it."

At a meeting of the Alumni Society of Bellevue Hospital, October 2, 1895, Dr. Charles C. Barrows read an interesting article on "Puerperal Eclampsia treated with *Veratrum* with great success," and reported several cases. He was followed by Dr. J. C. Edgar and W. J. Chandler, who agreed in the great efficacy of the drug, and both mentioned that it was rather remarkable that so far Dr. Fordyce Barker seemed the only enthusiastic advocate of *veratrum* among the great writers of the day. Dr. Mann quoted a case where a teaspoonful of the plain tincture of *veratrum viride* had been given by mistake and yet the patient survived.

It is a known fact that most writers on the subject dispose of it in as few words as possible, suggesting chloroform inhalations, hypodermic use of morphia, bromides or chloral by mouth or rectum, protecting injury from teeth by cork or roll of cloth between them, etc., but

very little is said about the one drug that acts almost as a specific, chiefly, I believe, because most physicians are afraid of the drug in sufficient doses to control the symptoms; still Dr. Norwood reports one case where an ounce was swallowed without causing death. This no doubt is due to the rapid elimination and its numerous channels of escape, the skin, kidney, bowels, and stomach as by vomiting in overdoses.

In the successful treatment of this condition, prompt, decisive, intelligent action, and that only, will avert the threatened calamity. As a matter of fact, the first question a physician should ask himself in determining the plan of treatment in any disease is, what are the indications? We all believe this condition results from toxemia (a poison in the blood), which by its action on nerve centres excites convulsions. The indications, then, are two: (1) eliminate the poison; (2) control convulsions. The more promptly and rapidly this is done, the greater chance of recovery our patient receives. Norwood's tincture of *veratrum viride* seems to me to meet these conditions if given in half-drachm doses every 20 minutes or half hour until the pulse is reduced to about 60 per minute. Until convinced by personal experience I will not believe a woman can have a convulsion with a pulse at 60 brought there by the action of *veratrum*.

After the convulsions are under control the pulse can be maintained at about 60 until danger is passed by an occasional small dose of *veratrum* if need be; or if the heart shows weakness it can be sustained with nitroglycerine or strychnia.

If *veratrum viride* cannot be shown both scientifically and clinically that it excels all other remedies in controlling puerperal eclampsia, it should make way for some other more potent drug. However, I firmly believe from my reading and clinical observation that where it has been fairly tested (not in 5 or 10 drop doses occasionally given, but administered in half-teaspoonful doses often enough to reduce the pulse to about 60 and kept it there for sufficient time), that its record of cures will surpass that of any other treatment yet tried. It should be remembered that a few cases will necessarily end fatally from a pre-existing nephritis, a cerebral hemorrhage or perhaps other conditions

that would prevent recovery, regardless of what treatment we might adopt. The only formidable rivals to veratrum are morphia or the lancet. Let us then compare them briefly both as to sedative and eliminating effects, for it is only in these respects that either can be of value in eclampsia.

Morphia is a remedy strongly recommended by some for subcutaneous injection in this condition in $\frac{1}{3}$ to $\frac{1}{4}$ -grain doses to control muscular action. To me it seems contra-indicated on theoretical grounds, for by its use for muscular control we are only treating a symptom, and the chief point, that of elimination, we are defeating, as morphia checks the secretions and at best only masks the symptoms of convulsions, in no way removing the cause. Veratrum controls convulsions by its sedative action on the heart and circulation, stimulating the skin secretion and eliminating the toxemia that produces the condition. It also relieves arterial tension by reducing the frequency and force of the heart. This can be done without danger of depression if the patient is carefully watched and stimulants applied if needed. This goes far towards allaying that irritation which excites convulsions. Morphia cannot produce this action. Veratrum lowers arterial tension, thereby lessening danger of cerebral effusion or cerebral hemorrhage—another advantage over morphia. A more profound impression can also be produced on the vasomotor nerve centres and spinal nervous system with veratrum. It is refrigerating in a far greater degree than morphia.

I quote the following from Wood: "When true esthenic arterial excitement is to be combatted in any disease (except gastritis), veratrum viride may be employed as a prompt, thoroughly efficient and very safe remedy. As an eliminative agent morphia can bear no comparison with veratrum. Morphia in some kidney troubles is contra-indicated, veratrum in none. It seems, therefore, that as a sedative veratrum compares favorably with morphia in eclampsia, while as an eliminative it excels it beyond comparison."

Compared with chloral, veratrum stands far in advance. Chloral is a powerful spinal and cerebral depressant, but in no sense an eliminative, consequently not to be ranked with veratrum. Wood says of

chloral in puerperal convulsions that "next to chloroform it is the best palliative, but only palliative, and must only be used to quiet the nervous disturbance until other remedies can have time to act."

As to venesection, what does bleeding accomplish that is not accomplished by veratrum? Bleeding lessens the force and frequency of the pulse, it is true, but no more markedly than veratrum. Moreover, it does this at the expense of impoverishing the blood, and this too is a malady already characterized by hydremia. Bleeding is sedative, of course, and we no doubt rid the system of toxic elements, but we are also losing life-sustaining elements which are invaluable.

In veratrum we accomplish all these conditions without the loss of blood simply by turning over the arterial supply into the venous system, and in addition are getting elimination by excretion; a point accomplished with no other treatment. In the absence of veratrum, venesection seems the proper means of tiding over a patient in eclampsia until something better can be used, but where we have a choice of selections, I am convinced our results would be better if preference is given to veratrum and it properly used in doses sufficient to control convulsions.

From theoretical grounds blood-letting can only be of temporary use and may even increase the tendency to convulsions. I quote the following from Shroeder: "If the theory of Traube and Rosenstein be correct, a sudden depletion of the vascular system by which the pressure is diminished, must stop the attack. From experience it is known that after venesection the quantity of the blood soon becomes the same though the serum taken from the tissues, while the quality is greatly deteriorated by the abstraction of the blood. A short time after venesection we expect to find the former blood pressure in the arterial system but the blood far more watery than previously; hence the quality of the blood having been greatly deteriorated the dangers of the disease will be increased."

This objection cannot be made to the use of veratrum, for we neither loose the quantity or quality by its administration, but we do quiet its circulation, reduce the arterial tension and eliminate the poisons (whatever they may be) that produces the disease. The hot pack recommended by some I believe advisable in all cases, with or without the use of veratrum as the attending physician may select, for its use is always indicated

for its action on the skin, thereby opening another channel for elimination and relieving the kidneys.

The third indication, that of a free purgation by the use of croton oil or elaterium, should always be given as soon as the patient can swallow. The rational treatment of puerperal eclampsia then seems to me as follows: As soon as we reach the patient and find a hard, bounding, rapid pulse, 140 to 160 or more per minute, give 30 minims of Norwood's tincture of veratrum and repeat the dose in 20 minutes or half hour until the pulse is reduced to 60 or 70 per minute. Apply at once the hot pack and in five to ten minutes give a full dose of elaterium or croton oil, as you may select. This being done, we are meeting all the indications, quieting a rapid, strong, bounding pulse, relieving arterial tension, controlling convulsions and opening every possible channel for elimination of the poisons by the use of veratrum, hot packs, and croton oil that it is possible to secure, and our aim, that of removing the cause, in the successful treatment of any disease, seems to me better accomplished than by any other mode of procedure yet suggested.

THE BACTERIAL FLORA OF SALT WATER FISH.

BY ROSS ANDERSON AND WALTER T. HASLER, 2ND YEAR MEN.

From the Pathological Department of the College of Physicians and Surgeons of Baltimore, Maryland.

This work was prompted by the spirit of investigation and undertaken to see what kinds of bacteria grow on and in the various organs of fish used as an article of food by man.

The fish from which these results were obtained are of eight varieties, viz., "yellow perch" (*Perca Flavescens*); "black bass" (*Centropistes Nigricanus*); "mullet" (*Mullus Barbatus*); "sun-fish" (*Pomotis Vulgaris*); "shad" (*Alosa Præstabilis*); "cat-fish" (*Pimelodus Catus*); "cod-fish" (*Morrhua Americana*); and the "herring" (*Clupea Harengus*).

These fish were obtained from a wholesale dealer in Baltimore, and were caught in the Chesapeake Bay during the months of February and March.

The fish were brought up from the bay in the evening and cultures were taken the next morning. Very careful technique was exercised, and the following precautions observed. In taking cultures from the various viscera the point of incision was carefully seared, and a sterile platinum needle smeared over the point from which the culture was taken.

The inoculations were first made into slant agar, and after growing twenty-four hours, two plate cultures were made with four dilutions. The bacteria, after being isolated, were transferred to slant agar, and from this pure culture inoculations into the various culture media were made.

All hanging drops were made from twenty-four cultures grown on nutrient bouillon. The various bacteria isolated are as follows: From the intestinal canal of "yellow perch" (*Perca Flavescens*), *Bacillus fluorescens nonliquifacens*; from the abdominal cavities of "black bass" (*Centropistes Nigricanus*), "mullet" (*Mullus Barbatus*), and "sun-fish" (*Pomotis Vulgaris*), *Bacillus pyocyaneus*; from the blood of a "mullet" (*Mullus Barbatus*), *Bacillus simulyphus*; from the intestine of a "shad" (*Alosa Præstabilis*), a bacillus belonging to the fluorescent group; and from the fin of a "cat-fish" (*Pimelodus Catus*), *Bacillus candicans* and the *Pseudo-colon Bacillus*.

The *Bacillus coli communis* was never found in the intestinal canal of any of the fish examined, as those found gave no gas production in sugar media, and one variety liquefied gelatin, while *Bacillus coli communis* does neither of these.

Salted "herring" (*Clupea Harengus*) was also examined, but was found to be sterile; salted "cod-fish" (*Morrhua Americana*) was also found to be sterile. The abdominal cavities of the "yellow perch" (*Perca Flavescens*) and "herring" (*Clupea Harengus*) were also found to be sterile; likewise the heart of the "mullet" (*Mullus Barbatus*) gave no growth.

The bacillus *pyocyaneus* was also isolated from the intestinal canal of a black snake.

John A. Amyot, M. B., of Toronto, Ontario, in 1891 examined the

NAME.		Morphology.		Stains.	Nutrient bouillon slant agar.				Gelatin stab.	Potato.	Gas production.				Liquefaction.	acid. acid.				Reaction.											
		Diameter over 1 mm.	Motile.		Spores.	Ordinary dyes.	Gram's stain.	Scum.			Turpid.	Dull.	Moist.	Surface growth.		Line growth.	Characteristic on agar plate.	Visible.	Luxuriant.		Dextrose.	Lactose.	Saccharose.	Grows at 20° C.	Aerobic.	Gelatin.	Casein.	Blood serum.	Nitrates reduced.	Indol produced.	Milk coagulated.	Faecal odor.	Chromogenes.	Fluorescence.
B. Fluorescens non-liquefaciens.	Eisenberg.	B.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
B. Pyocyaneus	Gessard.	B.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
B. Simultypus	Eberth.	B.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
B. Aquatilis Communis	Zimmerman.	B.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
B. Candidans	Frankland.	B.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
B. Pseudo-colon		B.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

intestinal contents of twenty-three fishes. The twenty-three were divided into fourteen varieties, viz., nine "pickerel" (*Stizostedion Canadensis*); two "sheep-head" (*Aplodinotus Grunniens*); two "black bass" (*Roccus Chrysops*); one "perch" (*Perca Americana*); one "broad mullet" (*Moxostoma Macrolepidotum*); one "moon-eye" (*Hyodon Ter-gisus*), and one German carp.

The fishes were examined within an hour of coming out of the water from a trap net at Port Stanley, Ontario (Lake Erie), during the month of August, 1901.

From the twenty-three fishes examined by Amyot, the *Bacillus coli communis* was not isolated. From these results, it appears improbable that water containing the *Bacillus coli communis* is ever contaminated by fish, and this is very important from a sanitary point of view, as it seems to overthrow the idea held by some authorities that "water containing the *Bacillus coli communis* may be contaminated by the excrement of fish."

It is also of vast importance to know that the pathogenic organism, the *Bacillus pyocyaneus*, found in the abdominal cavities of the above named fish, is capable of causing epidemic dysentery.

The results obtained from the examination of the salted fish show the efficacy of common salt as a preservative of meats.

Most of the bacteria found in the intestinal canal of fish belong to the fluorescent group, and are probably derived from the water they drink.

The morphological and cultural characteristics of six varieties are given in the following scheme.

We are indebted to Drs. Stokes and Hirshberg for assistance in carrying on the work.

CASE OF DOUBLE VAGINA, ONE CANAL LYING ABOVE THE OTHER.

BY DR. IRVIN HARDY, '03.

On September 18, 1902, I was called to see Mrs. B., primipara, aged 21; arrived at the house about 10 P. M. and found her in the first

stage of labor. After thoroughly cleansing my hands in the usual manner I made a vaginal examination. I found what I at first thought was a very much dilated urethra, but which I soon found to be an abnormal vagina situated immediately above the normal vaginal canal. I passed my finger into this upper canal and found it opened into the uterus above the internal os. It had a well-defined opening or os, whose circular fibres were distinctly palpable and which was doing its best to dilate. The normal os uteri was also dilating and for a time there seemed to be some question as to which opening in the uterus would give exit to the child's head which was presenting. After about three hours the normal os was fully dilated, but the labor pains did not seem to accomplish anything in the way of expulsion. This I attributed to deficient uterine force, due to the abnormal opening in the anterior wall of uterus. I now sent for my partner, Dr. R. Hardwick, who administered chloroform, and I applied forceps and delivered her of a normal male child, doing no more damage than lacerating the perineum, which was unavoidable. Both mother and child got along well.

WOUNDS OF THE THORAX.

BY DR. ISAAC R. TRIMBLE.

Operations involving the resection of ribs and the opening of the thoracic cavity for various troubles date back to the time of Hippocrates, 400 B. C. What we practice to-day is nothing new, but we have advanced step by step, each operator aiding by his experience those who come after him. During the last 25 years considerable has been done owing to the improved technic and to our increased knowledge of surgical pathology.

Whether we shall open up every wounded chest or whether we shall let them all go on the expectant plan is a question which has the weight of authoritative precedent on both sides. The truth lies perhaps in the middle ground as in so many other questions. Each case must be judged by itself. The nature of the case, the surroundings and the skill and technic of the operator must all be taken into consideration. Each

patient should get our best judgment. A careful study of the anatomy of the chest and its contents is essential before doing any operative work upon it. Besides this the experience of other surgeons should be considered and their cases gone over.

An article in the *Annals of Surgery* of May, 1902, by Dr. W. G. Le-Boutillier gives a good history of thoracic injuries involving the lungs and also the result of these injuries in his cases. The article by Dr. J. B. Murphy, of Chicago, read at the American Medical Association, 1898, "On Surgery of the Lungs," is by far the most complete that I have been able to find. Dr. H. B. Loomis, of New York, quoting an article in the *Medical Record*, of September 29, 1900, speaks of the introduction of nitrogen gas into the pleura to check hemorrhage and, by pressure, to prevent motion of the lungs and assist the healing of the tuberculous foci. This idea was advanced by Dr. Murphy in 1898. He found that when air was let into the pleural cavity it was absorbed in from a few hours to a few days. First, oxygen is absorbed most readily, second, carbon dioxid, and third, nitrogen gas, is absorbed very slowly, in fact nitrogen gas will remain in the pleural cavity and be unabsorbed from a few weeks to several months. So in diseases of the lung, Dr. Murphy used the latter gas to produce constant pressure and keep the lung collapsed and in that way to assist the cure. It has been found that after 12 or 18 months' pressure from gas the lungs are able to resume their function. Dr. Murphy says that to depend upon the introduction of gas into the pleural cavity, and trusting by that pressure to stop bleeding from an injured lung, has not been followed by good results. As in the case mentioned by Dr. Loomis, if the bleeding is from within the lung itself, one can see that the pressure and collapse of the lung by the gas would accomplish our object of checking hemorrhage, but in my opinion it is not good surgery to fill the cavity with the gas in hopes of checking hemorrhage when we do not know from what point it comes. Our duty in chest injury is to remove the foreign body, if there be one, cleanse the part, cutting off all lacerated tissues, and put the parts at rest so they will be better able to resist infection, and when infection does occur give free drainage and watch for all other complications that may arise.

Contusions of the chest or simple break of a rib without any complications are treated by putting the parts at rest. In contusions of the chest the only symptom of injury may be hemoptysis which may come on at once or be delayed several days, and may be due to injury of the lung or to some tuberculous foci in the lung. In chest injuries we look for pneumothorax, hemoptysis and emphysema, "the lungs may be injured without any of these symptoms, and yet having any one of these alone we can not say positively that the lung has been injured."

In the article of Dr. W. G. LeBoutillier, he mentions a case of rupture of the lung without fracture of the rib. It was in a boy who had been run over by a wagon, the wheels passing across his chest. When he was first seen he was in profound shock, having dyspnea, weak pulse, and increased respiration. The dyspnea was relieved by aspirating the right chest and evacuating the air. The boy lingered for some time, and on autopsy the only lesions were two small ruptures of the lower lobe of the right lung.

Penetrating wounds of the thorax may injure the intercostal arteries, heart, or large vessels, lung or diaphragm and may also extend into the abdominal cavity and injure its contents. Dr. Matas, of New Orleans, in the *Transactions of the Louisiana State Medical Society*, gives 245 reports on cases of injury to the chest, the majority of them being penetrating wounds. He states that hemorrhages are fatal that occur from the heart, aorta, large vessels, veins and arteries and the hilus of the lung, vena cava and vena azygos.

Emphysema is not always present, and may be due to the escape of air from the injured lung into the tissues, or may come from air entering the lacerated tissue and not from the lung. An alveolus of the lung may be ruptured and the rupture not extend through the visceral layer of the pleura. The air escaping into the connective tissue of the lung will travel to the hilus and then by the way of the mediastinum and be found at the root of the neck or around the lower end of the sternum. In extreme cases of emphysema it may be found necessary to incise the skin to allow the escape of air from the tissue. Emphysema is generally due to a fractured rib puncturing the lung.

Pneumothorax.—In lesions of the chest walls, air enters the cavity during respiration, but air from a ruptured bronchus enters the cavity

during expiration. In the latter case air entering the cavity may not get out and a plus pressure is exerted and death may follow from pressure or rupture into the mediastinum. This has occurred from a very small lesion of the lung in which air has escaped some time into the pleura or a small external opening into the pleura. Pneumothorax may be due to escape of air from the lung, bronchus or through the external wound into the thoracic cavity. The symptoms will be partial or complete collapse of the lung. Should the wound be a large one, five or six respirations will be sufficient to produce a collapsed lung, but should the wound be small and remain open some time, it may also produce collapse of the lung. The symptoms are the bulging of the intercostal spaces on the affected side, displacement of the heart, mediastinum and diaphragm and a corresponding displacement of the abdominal contents. Absence of respiratory murmur, a tympanic note on percussion, and distant bronchial breathing are also present. The breathing and heart's action will be correspondingly difficult in proportion to the amount of pressure in the pleural cavity. The cavity can be aspirated or the contents of the cavity turned out through the external opening. If the intrathoracic pressure continues and becomes greater, it is an indication that there is an opening of a valvular nature. This is an indication to aspirate or to turn out the air and blood clots from the pleura by an operation. The air in the pleural cavity compresses the lung, and in that way puts the parts at rest and assists in the healing of the ruptured air vesicles or blood-vessels.

In wounds of the thorax we cleanse the openings of entrance and exit, if there be any, and should the symptoms be urgent we operate and put the parts at rest, by this means assisting the healing process. If there is fluid in the pleural cavity, we should aspirate and if we find pus we must resect a rib and give free drainage. Do not at the first opening of the chest irrigate the pleural cavity. A simple opening through the intercostal muscle may suffice to empty the cavity, but it will be found better to resect one or two ribs, about the eighth and ninth ribs, at the posterior angle of the scapular, giving an opening two or three inches long, which will be sufficient for drainage. Should the pneumothorax increase to such an extent as to rupture the mediastinum death will occur from collapse of both lungs.

(To be continued.)

WILLIAM S. GARDNER, M. D., EDITOR,
6 W. Preston Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER,
Mt. Washington.
Telephone, C. & P., Tuxedo, 984.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE

VALE POST-GRADUATE COURSE.

Those of you who file your copies of the JOURNAL, and we hope you all keep it carefully put away along with the other dust-covered piles of papers and reprints, turn back to the corresponding time of last year and read the radiant reflections on the subject of the post-graduate course. Last year our assets were several headaches derived from the administration of sundry high-balls purchased with the profits of the course. The amount made may be easily computed as only one headache was allotted to each of the several members of the post-graduate faculty present at the annual meeting of that august body. Filled with high-balls and ambitions we sat ourselves down to our editorial type-writer and poured out our soul in praises of the good which we were going to do the profession, the world in general and our pocket-books in particular. We saw in a few years our spacious halls filled with post-graduate students. Vienna, Berlin, Paris and New York as centers of post-graduate work would pale into utter insignificance alongside of the Mecca for medical pilgrims which we had just inaugurated.

But alas for human hopes and ambitions! This year even the high-ball was missing, our assets, after all our just debts were paid, amounted to a goodly measure of altruistic ideals which were for the most part in the possession of Beck and Harry Friedenwald and even these opti-

mistic stockholders were not quite sure that some of these same ideals were not as Dead Sea fruit. At any rate they did not show them. At the last hour we realized that we had started the automobile of post-graduate instruction and had cast our precious hours before it like sacrificial victims before the Juggernaut. When the dust and confusion had cleared away we found that we had lost our office hours, our afternoon naps and our spare moments for reading while we had left us as guerdon of our toil the cast mantle of the consciousness of work well done. This with the overworked doctor in the city is apt to be a rather too plentiful reward.

And so it is that when the course opens next May there will probably be not only a deficiency in the number of students but in the ranks of the teachers as well.

We are constrained to borrow from the Bigelow Papers for our envoi:

"Now a dastardly notion is gittin' about
Thet our bladder is bust an' the gas oozin' out,
And unless we can mennage in some way to stop it,
Why the thing's a gone coon, an' we might as well drop it.
Brag works well at fust, but it aint jes' the thing
For a stiddy inves'ment the shiners to bring,
An' votin' we're pros'prou a hundred times over
Wun't change bein' starved into livin' on clover."

THE COMMENCEMENT.

The commencement exercises went off with the usual ceremonies which attend that annual function. One commencement is so much like another that we shall not attempt to describe the scene in Ford's Opera House. There were the customary flowers, expectant graduates and their proud relatives and friends.

The date of the event was April 30, at noon, and it will be noted that the commencement is being held later and later as the course of study is lengthened. Next year it will probably be later than ever.

The opening prayer was offered up by the Rev. John D. Boland, after which Dean Opie addressed the class. After he had finished his remarks he announced the graduates and conferred the degrees.

The prizes were awarded by the Rev. John D. Boland, as follows:

First Prize, Samuel T. Darling, of Maryland.

Second Prize, T. J. Cummins, of New Jersey.

Third Prize, F. W. A. Mayer, of New Jersey.

Fourth Prize, Wm. F. Evans, of Utah.

Worthy of Honorable Mention.

George E. Merrick, of Pennsylvania.

Frank H. Cutler, of Utah.

George L. Faucett, of Alabama.

Arter W. Deal, of Pennsylvania.

T. J. Brothers, of Alabama.

E. H. Cohoon, of Nova Scotia.

The orator of the day was the Hon. Olin Bryan, one of the State Senators. His address was full of interest and instruction and was listened to by all with a great deal of pleasure. There were seventy-seven in the class.

HOSPITAL APPOINTMENTS.

Resident Physician, Dr. L. J. Owen; Associate Resident Physicians, Dr. Z. P. Henry, Dr. S. P. Page; Assistant Resident Physicians, Dr. T. J. Cummins, Dr. W. S. Evans, Dr. Arter W. Deal, Dr. A. C. Biddle, Dr. Major M. Allan, Dr. C. W. Lurting.

Maternite Hospital.—Resident Physician, C. G. Laslie; Assistant Resident Physician, J. Plumer Cole.

Bay View Hospital.—Resident Physicians, Dr. Wright S. Sudler, Dr. A. Ferdinand Ries, Dr. George F. Sargent.

THE ALUMNI ASSOCIATION MEETING.

The annual meeting of the Alumni Association was held April 27 in the College Amphitheatre. Dr. John Ruhräh presided over the meeting in the absence of the President and Vice-Presidents. The feature of the evening was the annual address, which was delivered by Dr.

THE ALUMNI ASSOCIATION

COLLEGE OF PHYSICIANS AND SURGEONS

APRIL 27, 1903.

HOTEL RENNERT

OFFICE HOURS: 9 TO 12 P. M.

Clamsibus cervicalis parvum ssvi
 Corpus olivary
 Mices cum grano salis aa go .
 Celeritis infusio Ziv
 Pullus praevalis maceratis Zii
 Pisum Zes
 Taurus roastiannus Zv
 Prates irishibus in diognosone not
 Fungi good-to-eatibus Zii
 Femur hogii Smithfeldii Zi
 Lactuca a la francais Zas
 Lac congelatum Zi
 Caseus infectus
 alias Camembert Chessei frit
 Cunn Krakeritis Lostus Zi
 Decoctio coffeini cum
 extracto cowei Ziv
 Tabacos ad lib.
 Vinum sherri, sauterneii et
 champagni go . ad confusio
 In ft massa.
 Y - Masticate Thoroughly & effectually
 W. H. Stokes, pathologus
 Henry Beck, medicus
 F. D. Ganger, nose et-throaticus
 Melvin Cornthal, skinicus



Toasts

—o—

Toastmaster, PROF. WM. ROYAL STOKES

—o—

Reflexes and Reflections

PROF. GEO. J. PRESTON

Fear of Water

PROF. N. G. KEIRLE

Modern Games of Chance

PROF. STANDISH MCCLEARY

How to Get Home After this Banquet

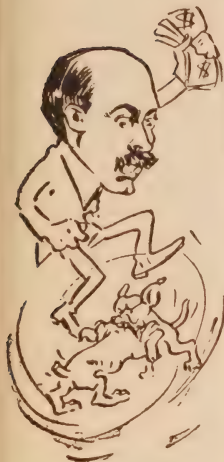
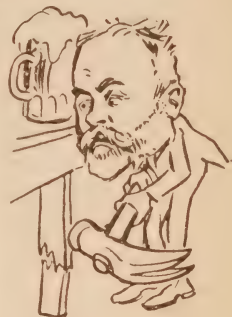
PROF. JOHN RUHRÄH

Strenuous Life of a President

DR. C. J. CUMMINGS

Prevention of Cruelty to Animals

DR. SAMUEL T. DARLING



Francis J. Snyder, of York, Pa. Dr. Snyder's talk was most enjoyable and was followed by the usual reports of the various committees. The JOURNAL Committee reported that the financial end of the JOURNAL was being held up fairly well by the men who receive the publication, but that a great many were in arrears. It would facilitate the business of the JOURNAL if those who receive it would send in their dollar a year promptly.

The JOURNAL came in for some complimentary remarks, but we are too modest to print them.

The election of officers was railroaded through with the usual rush, and considerable amusement was furnished by the most uproarious election of Dr. J. W. Chambers to the position of Second Assistant Secretary. This position was created for Dr. Chambers, as all the officers had been elected when it became evident that he both needed and wanted an office badly.

The officers as elected for the ensuing year are as follows:

President, F. J. Snyder, '87, York, Pa.; First Vice-President, J. J. McCarthy, '94, Baltimore, Md.; Second Vice-President, S. J. Darling, '03; Treasurer, C. E. Brack, '95, Baltimore, Md.; Secretary, H. C. Knapp, '96, Baltimore, Md.; First Assistant Secretary, M. S. Rosenthal, '91, Baltimore, Md.; Second Assistant Secretary, J. W. Chambers, '78, Baltimore, Md.

The President appointed the following members to act as Executive Committee: A. C. Harrison (Chairman), H. G. Beck and G. M. Litzinger.

The meeting then adjourned to the Hotel Rennert, where the annual dinner was served.

THE BANQUET.

The members of the retiring Executive Committee, Beck, Sanger and Rosenthal, deserve the highest praise for the most skillful way in which the dinner was arranged and the program carried out. Of late years the banquets have been getting better each year. In former days there used to be a grand spread with sufficient alcohol to make every-

body very happy. Then came a period when the banquets were not what they should have been. This was followed by a revival and this year's was the best of the lot. The dinner was well served and was good; the menu cards were wonderful productions, which we have copied for the benefit of those who could not attend; while the speakers did not go over the allotted time and did not sermonize or reminisce.

The menu cards speak for themselves. The cartoons are all splendid. McCleary did not think that his was good, for he said that it differed in two ways. In the first place he was sure that he was better looking, and in the second he had money in his hand. He will be seen watching his favorite dogs fight. Dr. Keirle is injecting one of his victims with the rabies virus, and it was remarked how much he looked like Pasteur. Dr. Stokes, who is also City Bacteriologist, has discovered a new bug, and has it under a lens for close inspection. Whether it was the product of copious libations of imagination water or not is not definitely known. Dr. Preston is anxiously testing the patellar reflex on a broken table leg, while a glass of foaming nectar waits his attention. Dr. Ruhräh is instructing a small student in the noble art of spelling. This is a hit at his having criticized the student who wrote that a dose should be "repeted as kneeded." Dr. Darling, who was Dr. Keirle's assistant during the past year, is chasing a rabbit with a butterfly net. The exact meaning of the corkscrew we leave to the imagination of those who know Darling. The artist says that it is a trephine to operate on a rabbit, but there are those who say that it is something else. Dr. Cummings, the Class President, is seen in one of his favorite and very characteristic attitudes, that of eloquent appeal in a Bryanesque position.

Dr. Stokes, as toastmaster, was in a most happy vein of humor and had a little joke for every one. It was suggested that he be made perpetual toastmaster. Dr. Preston was up to his usual form in responding to the toast of Reflexes and Reflections. He told the customary bright stories and finally wound up in some poetic thoughts on his subject which we have the honor of printing in this issue of the JOURNAL. Dr. Keirle was the speaker of the evening, however. He said that he had made but three toasts before in his life and that this was the fourth. Those who remember his toast about ten years ago can well imagine the treat

that was prepared for this year. Dr. Keirle had his audience with him from the start and every sentence sparkled with wit. He told some good jokes and of some very humorous experiences. Dr. McCleary spoke with his customary wit of the modern games of chance. He told his usual new story and wound up with some verses about poker written in imitation of the style of Omar Khayyam. (They were not original, or we should print them.)

Dr. Ruhräh told in doggerel how to get home from the banquet. An emasculated copy is subjoined. Like some other famous papers, we give "all the news that's fit to print." Some of the fathers of young hopeful doctors would probably think it mean to publish part of the things about their sons, so we omit the doings of the White Ribbon boys. Dr. Cummings gave an account of the strenuous life that he had led as President of the class and told it very pleasantly. Dr. Darling wound up the dinner by stating his views on the prevention of cruelty to animals. He was "real mean" to some of the members of his class by telling about "Molly" and her friends. Darling made a hit with his speech and kept the boys squirming in their seats wondering what he was going to say next.

REFLEXES AND REFLECTIONS.

BY DR. GEORGE J. PRESTON.

Of all the silly, jejune themes,
Without the slightest fraction
Of wit or sense to balance it
Is mine, on Reflex Action.

And then, to make the horror worse,
To add to my dejection,
This dumb committee needs must add
The serious word, Reflection.

Percussion, hammer's ancestry,
Is great; 'tis hard to match it;
Its sire the Indian's tomahawk,
Dam, like G. W.'s hatchet.

The neuropath goes forth to war
Touched by no dread misgiving,
His faithful weapon by his side,
To hammer out a living.

We watch the pupils wax and wane
When danger signals fly,
O shade of Argyll-Robertson!
We wink the other eye.

And when we ponder long upon
Some treatment harsh and drastic,
To make assurance sure we test
The reflex epigastric.

When all our wits are at an end,
Our brain reduced to jelly,
In diagnostic deep despair
We scratch upon the belly.

As symptoms squirm and shift about
And sadly need correction,
We find the knee jerk much the best
Of all the genuflexions.

My Muse is modest and reserved,
And I will not o'ertask her
To tell what private things are stirred
By tickling the cremaster.

If things should come to direst straights
With bells about to toll,
We get as low down as we can
And test the very sole.

And after each reflex is tried
In each especial section
With diagnosis still unmade
We sit down to reflexion.

If I had closer watched the case,
If I had better dosed it,
Had thumped, palpated, listened more,
I might have diagnosed it.

Had I not been quite so cock sure,
 Called a consultant in,
 He doubtless would have saved the case,
 And also got the tin.

I must not stir your memory
 Of merits or deflections,
 For physiologically that would be
 A reflex of reflections.

But these reflections now must end,
 Lest fatigue products enter,
 To play the devil with the cord
 And bust the reflex centre.

There is one school in this broad land,
 Safe anchor in distress—
 It is the glorious old shebang
 Yclept the P. & S.

Reflection is a sorry thing;
 My head aches, and I think
 It's just about the proper time
 To take another drink.

HOW TO GET HOME AFTER THE BANQUET.

BY DR. JOHN RUHRÄH, '94.

Now hearken, all ye gentles, to this, my humble toast,
 And please don't take it badly if you get a little roast;
 For toasting is a sort of thing that is best done by heat,
 And roasting is akin to it, and you are easy meat.
 Like Arthur, King of Camelot, who had his table round,
 At which he always feasted and where he might be found,
 So this good class of naughty three is like to this great sport,
 And may be found most any night at Fosbender's resort.
 But more of this before I stop; I first must settle quite
 The question that is set for me, How to get home to-night?
 Each face I see, is filled with glee, at this most awful query,
 How to get home to-night, indeed, and Brack already leery.
 "A home is a horrible handicap when a lad would fain be free,"
 But home is a most attractive place when the clock points half past
 three.

The married men as ye all ken must get home bright and early,
Else the wife at home will fume and foam and treat them a wee bit
surly.

The bachelor boys, with their simple joys, may stay as late as they care,
But when keyholes dance, as they do for France, you can sometimes hear
them swear.

Like death and the tax, old homely facts, this question confronts each
one of you,

Unless you get tight and stay out all night it surely will make fun
for you.

Now Cotton smiles at the thought of miles, and I hear him answer back,
If you want to go to see the show, I'll order up a hack.

If Knapp would sell his phonograph, we could hire a special train;

If Sudler's tips were only ships, we'd sail the bounding main.

Dobbin and Brack and good friend Page would have a baby carriage.

Oh, Sanger, and Blake, and Lockwood, too, what do you think of marriage?

Trimble can ride on a traction car where he don't have to pay any fare,
And Mitchell will drive at a furious rate behind his speedy mare.

Hayden will sail on a poker chip on the dangerous sea of chance,

And Dr. Keirle, in a rabid swirl, will hurry in mad dog pants,

Beck will go on his hobby horse, on a honeymoon you'll find him,

And it won't be long if he needs a thong that an apron string will bind
him.

Opie will go on triumphal march to the tune of a uterine sound,

While Conrey and Hoag are still in vogue with the latest tips to be
found.

Chambers in bed at an early hour will dream of tumors fantastic,

While phantom shapes like ugly apes raise belly walls elastic.

Preston can ride, like a Valkyrie, on a gyrus hippocampus,

While Hirschberg gall his elbow crook on an old dispensary dam cuss.

Readily, easily gliding along, entirely and completely,

See Bevan go with rhetorical flow and a figure turned quite neatly.

I was going to say in a jocular way that he went along most texturally,

I feared for a rhyme, but I found it in time, its thoroughly and effectively.

Fort will go in his shooting clothes of an epileptic fit,

And Jones sail in, if the right side win, and he won't have to worry a bit.

See Rosenthal, who knows it all, with his cystoscopic grin,

His appetite is such a sight, but he knows that it costs like sin.

To-night he'll ride by McCleary's side on the back of an old night mare,
 While forty devils will have their revels in friend McCleary's hair.
 Magruder smiles like Sunny Jim with the smile that won't come off,
 While Baby Ned, at home in bed, does at his daddy scoff.
 And Toastmaster Stokes with quips and jokes is a sinner diabolic,
 His hot air jest has so much zest that I fear he has wind colic.
 He's gotten infected, it's plain to see, with bacillus talk-a-lotibus,
 And you see how he keeps his wine space clear with a thirst like a hip-
 popotamus.

But he feels the glow come up from below above his diaphragm stealing,
 And he loves the charm of the very warm champagne and brandy
 feeling.

I'll Gamble it's Pleasant for you to hear these Knox there as easy as
 Canby,

I'm off my Base, and I'll have to Brush up, or Coroner Requardt will
 hang me.

And now to the class I raise my glass and to your wine dispatch you;
 Good naughty three, how good ye be, and here is looking at you.
 You will be late if you get a skate, and the jagger wagon get you,
 But you carry it well, so the gossips tell, and they are right I'll bet you.
 Now in the school is Mr. Hoole, sometimes called Mr. Dooley,
 He'll pictures flash and take your cash and he will do it truly.
 And Mayer and Coon in one small room together lived elated,
 Till one fine day, so the surgeons say, they both were operated.
 Cohoon and Edgar B. are boys that never stoop to folly,
 They love each other well and so—they even share their Molly.
 Take me to Greenmount's peaceful shade in a casket neat and natty,
 Said Courtenay Allen to the boys, and let me lie with Hattie.
 McMillan is true to his Sadies, and his peaches and his Pearls,
 Or at least he's as true as he dares to be, for he has a hundred girls.
 Wagner works like a cascade, that is, while you are asleep,
 He's fond of a laugh, and fond of a calf, at which he loves to peep.
 Parson Evans' woe will surely grow when he hears how T. J. C.
 On a side street with a maiden neat some of his friends did see.
 But Cummins smiled, for his work, you know, was given him by allot-
 ment,
 So he went out that night while a little tight to practice up ballotement.
 Sprague's mental feat is hard to beat, but Darling does attain 'em,
 They both have got the same, you know, mental caput succedanum.

Charles Cummings talks both day and night with presidential dialogue,
 But a man with a wooden head you know will live and die a log.
 I see in his face, in which there's a trace of knowledge encyclopedic,
 That he knows I stole this pun from Lowell, from his famous Fable for
 Critics.

Oh, poor old France has had a dance with books and babies working,
 He's lost, I'm afraid, for the culture is made and old Dan Cupid is
 working.

There are others I know who are not a bit slow, and among them I see
 Brother Lurtin,

But at certain request on him and the rest I must now draw the curtain.

Postscriptum.—Take these warning notes and bear them in your head,

Don't either look to right or left until you are in bed;

And don't go near the red-light streets with girls in scarlet clad,

Else Rosenthal might get you and then you'd have it bad.

Don't take a drink, lest you be dry next morning when you wake

With bursting head and wish you're dead and buried in the lake.

Don't borrow money from your friend, and don't you be a lender,

And don't go up on Eutaw street to the Hotel de Fosbender.

But all these things I know you'll do, no matter what the morning,

And when you take a bracer then remember I gave warning.

And now old Naughty Three good bye, God bless you all with plenty,

For as the darkening years go by

You'll often think with many a sigh

On these good days of jollity

When you were four and twenty.

Personal Notes

DR. HERBERT J. B. BELCHER, '03, was married to Miss Bartlett, of New York, on May 11, 1903. Dr. and Mrs. Belcher will reside in Baltimore, where the Doctor expects to practice.

DR. GEORGE J. PRESTON, secretary of the Lunacy Commission, and DR. EDWARD M. BRUSH addressed the Bar Association upon the laws concerning the commitment of insane persons.

At the Johns Hopkins Historical Club, DR. JULIUS FRIEDENWALD brought out the fact that DR. PHILIP SYNG PHYSICK of Philadelphia discovered and was the first to make use of the stomach tube.

DR. J. H. BOYLES, '03, of North Carolina, was appointed interne at the Nursery and Child's Hospital for the ensuing year. Dr. J. I. France, who was there last year, will spend the summer in Washington.

JAMES COLVIN HALL, '79, died suddenly from heart disease while attending a lecture in Millerstown, Pa., February 11, aged 48. At a meeting of the physicians of Perry, Juniata and Snyder counties, held February 16, memorial resolutions were adopted.

DR. W. A. McMILLAN, '03, who is now located at Charleston W. Va., was married to Miss Elenora Oen of this city. Mrs. McMillan was formerly a nurse at the Baltimore Eye and Ear Hospital, at which institution Dr. McMillan acted as interne while studying medicine.

At the Annual Meeting of the Medical and Chirurgical Faculty in April, DR. HARRY FRIEDENWALD presented a portrait of his father to that society. The presentation speech was made by DR. LATIMER. The portrait will be hung in the Assembly Room in the Faculty Building.

DR. JAMES H. FINCH, '95, who is a prosperous practitioner in Champaign, Ill., was married on the tenth of June to Miss Helen Mary Trevett of the same place. The ceremony was performed in the First Presbyterian Church and was followed by a reception at the bride's home on North Elm Street. Dr. Finch took an extended tour in Europe and the Holy Land last year with Dr. Nicholas Senn, of Chicago.

DR. ADOLPH O. SCHOENIGER, '02, of Newark, N. J., died on May 2, at the home of his parents in that city. The funeral was held on May 5 from the First German Reformed Church, six of his professional friends acting as pall-bearers. Among them his classmate Dr. Charles Bruckner. All those who knew Dr. Schoeniger will learn with sorrow that a life which promised such a brilliant future has been closed.

The following members of the College Faculty read papers at the annual meeting of the Medical and Chirurgical Faculty of Maryland: Drs. Julius Friedenwald and Louis J. Rosenthal: "A report of all cases of removal of foreign bodies from the stomach." Dr. T. R. Brown: "Some minor communications from the clinical laboratory." Dr. William Royal Stokes: "The pathology of smallpox with lantern-slide illustrations." Dr. L. K. Hirshberg: "The effects of the streptococcus on the cortical nerve cells in meningitis."

DR. E. W. SPRAGUE, '03, of New York, has been appointed interne at the Robert Garrett Free Hospital for Children and will spend the summer at the hot weather home of that institution at Mount Airy, Maryland. Sprague took the examinations for a position as Resident Physician in the Newark, N. J., City Hospital, and out of thirty-five applicants passed first. There were nine examiners and he passed first in eight of the examinations. When the Garrett Hospital comes back to town he will go to Newark to take up his work there. The JOURNAL congratulates him on his success.

Our beloved chief, the editor, DR. WILLIAM S. GARDNER, has purchased a house at number six West Preston street and has removed his office and residence to that address. The JOURNAL has now a home office that is really consistent with its dignity and standing. Hereafter all official communications to the editorial staff may be addressed him there. For the benefit of those who have not heard it, we may say in his absence that he has a charming wife and two very bouncing boys. The oldest boy, named after his father and looking as much like him as one pea resembles another, will soon assist his father in the editorial work of the JOURNAL. He has already been engaged to tear up the rejected manuscripts that are unaccompanied with stamps for their return.

FAIRMONT, W. VA., April 17, 1903.

Dear Doctor.—I don't remember whether I answered your last letter or not, but any way, as my card index system has just arrived, I want to thank you for putting me next, and to show you what I managed to get out of it.

I enclose you one each of my blanks, and hope you will approve of them as thoroughly as I do. It looks to me as though they were complete, at any rate I do not see any room to improve them, for the purpose intended. For my work they just fill the bill.

I moved in here about the first of the present month, and have already had my first patient. She is doing splendid; this is her 9th day. I did a curettement and double ovariectomy; she did not take the anesthetic very nicely, and we were one hour and forty minutes from the time the anesthetic was started until the dressings were on and the patient ready for bed. Not so bad, when you take into account the fact that it was my first one, the nurse and I had never worked together before, and things were a little slow in coming. I expect to improve a little on that time as I become more familiar with the work.

Dr. Cruikshank was to have given the anesthetic, but did not reach us until the knife was in use, so missed being in on the early part of the game. He, Dr. Cruikshank, says that I have no excuses to offer, as the work was done with dispatch, and after the regulation manner.

Cruikshank is all right, and is doing mighty good work. I only hope he will not get disgusted with the place, and pull his freight.

Riedy has fell heir to something really rather nice. I don't know just what his income is, but judge something like \$2500 per year, not so bad to begin with. I have not seen him since the night of his arrival, but am frequently in correspondence with him. He reports everything lovely. Our people seem to like him, and are disposed to push him along.

Well, old man, there is nothing more of interest to say to you, so will close. Remember me kindly to Beck, Ruhräh and others too numerous to mention.

Mrs. Hill joins me in sending kindest regards to yourself and Mrs. Brack. Hoping to hear from you as the opportunity may present itself,
I am

Truly and fraternally yours,

F. W. HILL.

ADRENALIN IN HAY FEVER

"Adrenalin
is one of the
greatest
discoveries
of the age"
Clarke Gapen,
M.D.
Madison, Wis.

The world
is deeply
indebted to
Takamine for
his discovery
Dudley S.
Reynolds, M.D.
Louisville, Ky.

SOLUTION ADRENALIN CHLORIDE

undoubtedly meets the therapeutic indications in Hay Fever more fully than any other agent.

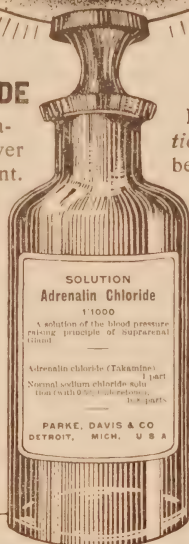
It controls the catarrhal inflammation as no other astringent can.

It allays the violent paroxysms of sneezing and profuse lacerimation.

It reduces the severity of the asthmatic seizure.

It prevents depression by stimulating the cardiac muscle and cardiac motor ganglia.

In ounce g.-s. vials.



METHOD OF APPLICATION.

For use in Hay Fever *Solution Adrenalin Chloride* should be diluted with four or five times its volume of normal salt solution. It may be sprayed into the nose with a small hand atomizer or applied on a pledget of cotton, and a drop or two may be instilled into each eye to relieve the congestion and swelling of the lids. One or two applications daily usually afford complete relief.

In ounce g.-s. vials.

PARKE, DAVIS & COMPANY

LABORATORIES:

DETROIT, MICH., U.S.A.; WALKERVILLE, ONT.; HOUNSLOW, ENG.

BRANCH HOUSES:

NEW YORK, CHICAGO, ST. LOUIS, BOSTON, BALTIMORE, NEW ORLEANS, KANSAS CITY, INDIANAPOLIS, MINNEAPOLIS, MEMPHIS, LONDON, ENG.; MONTREAL, QUE.; SYDNEY, N.S.W.; ST. PETERSBURG, RUSSIA; SIMLA, INDIA; TOKIO, JAPAN.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S.....Ohio.
E. PARMLEY BROWN, D. D. S.....N. Y.
A. L. NORTHROP, D. D. S.....N. Y.
E. L. HUNTER, D. D. S.....N. C.
W. W. WALKER, D. D. S.....N. Y.
OSCAR ADELBURG, D. D. S.....N. J.
G. MARSHALL SMITH, D. D. S.....Md.
C. M. GINGRICH, D. D. S., Resident.....Md.
R. B. DONALDSON, D. D. S.....D. C.

H. A. PARR, D. D. S.....N. Y.
J. EMORY SCOTT, D. D. S.....Md.
C. L. ALEXANDER, D. D. S.....N. C.
M. M. MAINE, D. D. S.....Conn.
J. W. DAVID, D. D. S.....Texas.
A. C. BREWER, D. D. S.....Md.
J. ROACH, D. D. S.....Md.
J. HALL MOORE, D. D. S.....Va.

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

WILLIAM G. FOSTER, D. D. S. GEORGE D. HARDY, M. D., D. D. S.
EDW. HOFFMEISTER, Ph. D., D. D. S. W. W. DUNBRACCO, D. D. S. GEO. V. MILHOLLAND, D. D. S.
L. M. PARSONS, D. D. S. H. M. LEVER, D. D. S. C. R. STEWART, D. D. S.
I. K. BURGESS, D. D. S. J. C. SUTHERLAND, D. D. S. CHAS. THEBERATH, D. D. S.
HARRY E. KELSEY, D. D. S. C. H. CARSON, D. D. S. C. S. GORE, D. D. S.
L. F. PALMER, D. D. S. L. D. CORIELL, D. D. S. A. C. HARRISON, M. D.
S. B. GRIMES, M. D. S. G. DAVIS, M. D.

The Sixty-Fourth Annual Session will commence on the 1st of October, 1903, and continue until May, 1904.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD

PROTAN

(Tannin Nucleo-Proteid)

The Ideal Intestinal Astringent

TASTELESS, ODORLESS, NON-TOXIC

PROTAN is not only free from *local action* in the stomach, but exerts *its astringent effects upon the entire intestinal canal, from the duodenum to the rectum.*

PROTAN yields prompt results in all forms of diarrhea---acute catarrhal enteritis and chronic diarrhea.

PROTAN is a specific in infantile diarrhea, entero-colitis and cholera infantum. Furnished in powder form and in tablets.

INTRODUCED BY

H. K. MULFORD CO.

Chemists

Philadelphia

New York

Chicago

LIBERAL SAMPLE UPON REQUEST

College of Physicians and Surgeons OF BALTIMORE.

FACULTY

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Medical Jurisprudence and Director of Medical Pasteur Institute.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, Toxicology and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, A. B., M. D.,
Professor of Obstetrics.
- WM. ROYAL STOKES, M. D.,
Professor of Pathology and Bacteriology.
- HARRY FRIEDENWALD, A. B., M. D.,
Professor of Diseases of the Eye and Ear.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- O. HAMPSON JONES, M.B., C.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MOCLEARY, M. D.,
Associate Professor of Histology and Pathology.
- CHARLES E. BRACK, PH. G., M. D.,
Associate Professor of Obstetrics.
- JOHN RUHRÄH, M. D.,
Clinical Professor of Diseases of Children.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Clinical Professor of Diseases of the Rectum.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MOGLANNAN, PH. G., M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- MELVIN ROSENTHAL, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- ALBERTUS COTTON, M. D.,
Associate Professor of Orthopedic Surgery.
- ARCHIBALD H. HARRISON, M. D.,
Associate Professor and Demonstrator of Anatomy.
- GLENN M. LITSINGER, PH. G., M. D.,
Demonstrator of Obstetrics.
- A. SAMUELS, PH. G., M. D.,
Demonstrator of Chemistry and Assistant in Genito-Urinary Surgery.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- JOHN MASON KNOX, JR., M. D.,
Demonstrator of Pathology and Physical Diagnosis.
- CHARLES B. CANBY, M. D.,
Demonstrator of Pathology.
- OTTO C. GLASER, A. B.,
Demonstrator of Embryology and Comparative Anatomy.
- L. K. HIRSBERG, A. B., M. D.,
Demonstrator of Bacteriology and Assistant in Neurology.
- C. W. G. ROHRER, M. D.,
Demonstrator of Pathology.
- L. J. ROSENTHAL, M. D.,
Demonstrator in Clinical Laboratory and Assistant in Diseases of Stomach.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. ULLMAN, M. D.,
Assistant Demonstrator of Anatomy.
- OTTO SCHAEFER, M. D.,
Assistant in Eye and Ear Diseases.
- W. EDWARD MAGRUDER, M. D.,
Assistant in Diseases of Children.
- CHARLES D. STEENKEN, M. D.,
Assistant in Diseases of the Eye and Ear.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1893, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Table of Contents Page III.

Issued Quarterly

Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION

OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS

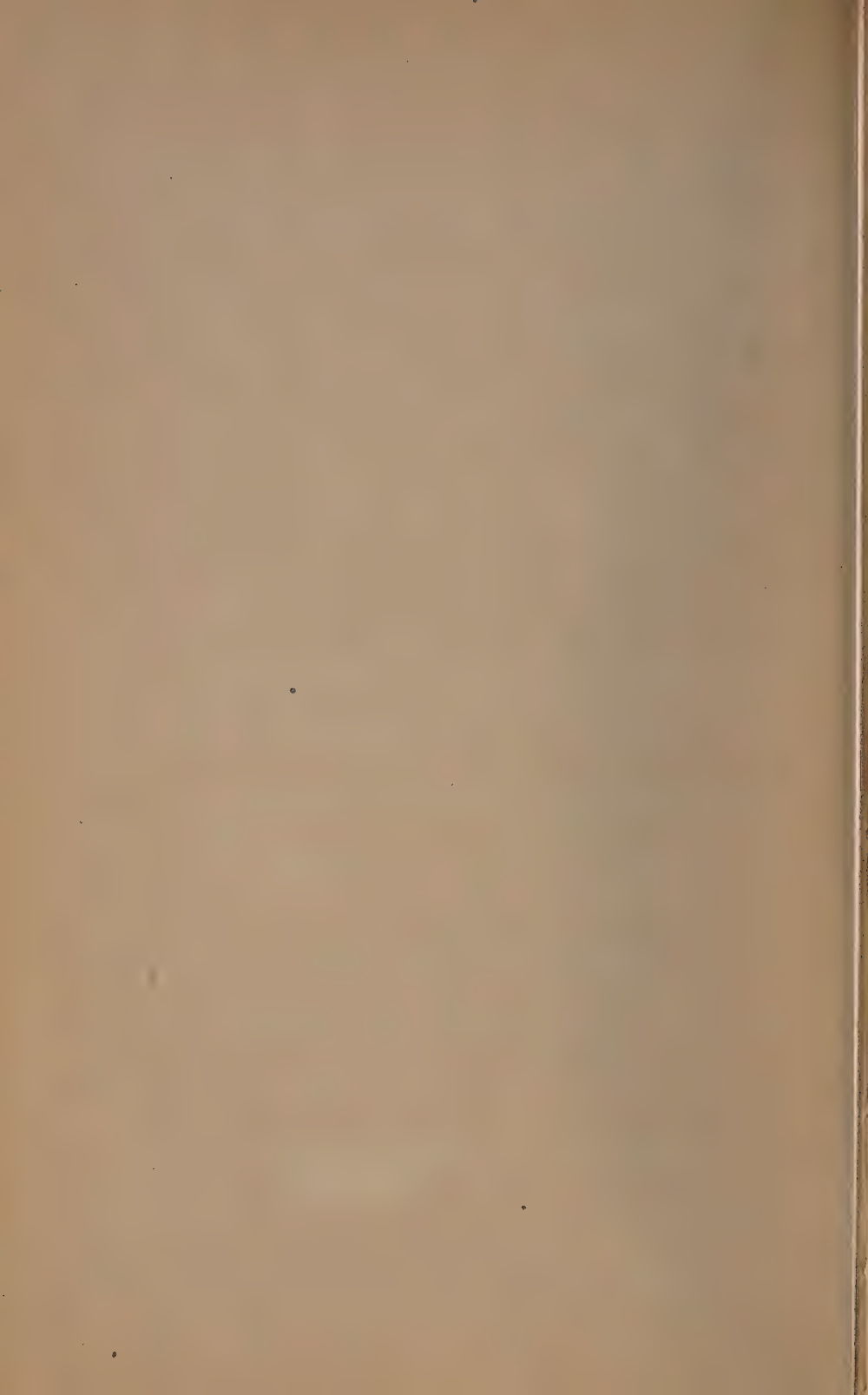
BALTIMORE.

Vol. VI

No. 3

OCTOBER, 1903

PUBLISHED AT
Baltimore and Eutaw Sts. Baltimore, Md.



The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—DR. THOS. S. LATIMER.

Director.—DR. N. G. KEIRLE, A. M.

Chief of the Laboratory.—DR. N. G. KEIRLE, JR.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Personal Notes.

DR. S. A. REICH, '02, is located at 118 Bowens St., Jersey City, N. J.

DR. GEORGE L. FAUCETT, '03, has settled in Gadsden, Ala., and is doing very well.

DR. CHARLES J. CUMMINGS, '03, has located at 235 East Fourth St., Williamsport, Pa.

DR. BENJAMIN HEWLETT, '78, died at his home, Brogueville, Pa., August 14, aged 56 years.

DR. JOHN H. DOYLE, '02, opened an office at 185 North Main St., Fall River, Mass., August 6, and is doing well.

DR. CHARLES W. VOGEL, '95, who is in the Marine Hospital Service, has been transferred from San Francisco to Manila, P. I.

DR. E. VAN HOOD, '84, of Ocala, Florida, made an extended trip through the Western States the past summer, and met many Alumni.

DOES EVERYTHING

that *syrups* of hypophosphites do, that is beneficial.

DOES NOTHING

that *syrups* of hypophosphites do, that is detrimental.

AROMATIC SOLUTION OF HYPOPHOSPHITES

Manufactured by
HYNSON, WESTCOTT & CO.,
Charles and Franklin Sts.,
BALTIMORE, MD.

Pint samples furnished upon application.

LAPACTIC PILLS

R

Aloin, S. & D.	gr. $\frac{1}{4}$
Strychninae,	gr. $\frac{1}{60}$
Extr. Belladonnae,	gr. $\frac{1}{8}$
Ipecacuanhae,	gr. $\frac{1}{12}$

M: et ft. Pil. No. 1.

The best and most reliable laxative pill ever offered the profession. The formula and name were originated by us, and because of the freedom of our Aloin from any resin of aloes or resinified aloes, due to our manufacturing it ourselves, Lapactic Pills never gripe and never fail. This cannot be said of the many substitutes offered the profession and the trade. Hence, please specify on your prescriptions and orders

SHARP & DOHME

CHICAGO.

BALTIMORE.

NEW YORK.

NEW ORLEANS.

NEW CITY HOSPITAL

Connected with the College of Physicians and Surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

READY RELIEF AND QUICK REPAIR ARE SURE RESULTS WHEN

Resinol Ointment

Is used for minor injuries, burns, boils and acute inflammations of the skin and muco-cutaneous surfaces. It is a specific for itching piles and allied troubles, and the best known local remedy for eczema in any form.

KEEP THE
BABY'S
SKIN
CLEAR
AND
HEALTHY.



Resinol Soap has been used exclusively in this baby's bath from birth, and her perfect skin and luxuriant hair excite wonderful interest and admiration..

AS A NUTRIENT SOAP
FOR THE SKIN . . .

Resinol Soap

IS WITHOUT PARALLEL.

It nourishes the underlying tissues, prevents congestions and eruptions, obviates waste and atrophy, thus preventing scurf and wrinkles. It is superior to all others for the hair and scalp.

SAMPLES SENT ON REQUEST.

Resinol Chemical Co.,

GREAT BRITAIN BRANCH,
97 New Oxford Street,
LONDON, W. C.

BALTIMORE, MD.,
U. S. A.

CHAS. MARKELL & CO.,
SYDNEY, N. S. W
Agents for Australasia.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

RÉSUMÉ OF THE GYNECOLOGICAL WORK AT THE CITY HOSPITAL FROM MAY 1 TO SEPTEMBER 15, 1903.

BY DR. WILLIAM S. GARDNER, '85.

A brief résumé of the work in gynecology at the City Hospital during the past summer will give some idea of the character of the work done and also an opportunity to discuss briefly the methods employed.

This report embraces only those cases in the City Hospital which came under my care. There were a number of other operators who had cases in the private section of the hospital during this period, but reports of none of these cases are included. In my own service from May 1 to September 15, eighty operations were performed.

The following table shows the variety of operations done and the number of each:

Abdominal Sections—

Hysterectomy for infection of uterus and appendages.....	8
Hysterectomy for myomata	2
Ovarian tumor	1
Resection of ovaries	2
Appendices removed	4
Tubes and ovaries removed.....	5
Tubes removed	1
Extra-uterine pregnancy	2
Gilliam's round ligament suspension.....	11

Vaginal Sections—

Hysterectomy for cancer.....	2
Hysterectomy for infection	1
Anterior section for removal of cystic ovary.....	1
Posterior section for extra-uterine pregnancy.....	1
Posterior section for pus.....	8
Uterus dilated and curetted	21
Uterus curetted for cancer.....	2
Lacerations of perineum repaired.....	5
Complete prolapse of uterus.....	1
Puerperal abscess in abdominal wall.....	1
Vulvo-vaginal abscess.....	1

—
80

Taking up the first mentioned, the hysterectomies for infected uterus and appendages: these cases belong to the class that are ordinarily diagnosed salpingitis or pyosalpinx. But it has been found that the removal of the tubes and ovaries alone does not always cure the patient. Also in some cases the adhesions are of such a character that it is a simpler and safer operation to remove the uterus than to leave it. The general rule followed is, that where the uterus is large, with extensive adhesions and complete destruction of the tubes and ovaries as useful organs, to remove everything down to the vagina.

The method of operating is to select the side that can be most readily separated; tie and cut off the broad ligament in sections down to the cervix; tie off the uterine artery by a stitch passed toward the cervix, but not taking in any cervical tissue; cut through the cervix; tie the opposite uterine artery, and the remainder of the broad ligament from below upward. The stump of the cervix is then covered with the flap of peritoneum from the anterior and posterior uterine walls, and any gaps in the broad ligaments are closed. The pelvis wiped dry with gauze or flushed with salt solution, according to the case. Drainage is only resorted to when presumably virulent pus has been unavoidably set free. In these cases a large gauze drain is used.

The Trendelenburg position is used always and the abdominal cavity packed off with gauze.

There was nothing unusual in the operations for the two myomata. The operation in each case was similar to that already outlined, but there being no adhesions, was much simpler. One of the myomata was remarkable for the fact that it occurred in a young woman of 23 and consisted of a relatively thin shell filled with fluid. Upon careful microscopical examination a focus of sarcoma was found within the myomatous growth.

The ovarian tumor removed was of the multilocular variety. The separate sacs were small but so numerous that the tumor was as large as a seven months pregnant uterus. The patient had the typical facies ovarina which is now so rarely seen.

The two operations for resection of the ovaries were both done for hematoma of the ovary. One case was in connection with a Gilliam's operation; in the other case a small tumor was felt on the ovary, which from its mobility, tenderness and history of having been painful for a long time, a diagnosis of hematoma was made. The ovary was resected and the patient has been entirely free from pain.

The appendix operations were all done in connection with other operations. In a number of instances the appendix was adherent to the inflamed tube.

In four cases one or both appendages were removed, the uterus not being removed. In one case, as only the tubes were involved, they were removed and both ovaries and the uterus left.

There were two cases that presented the classical signs of ruptured extra-uterine pregnancy. Both were immediately sent into the hospital and operated upon. Each had lost a quantity of blood into the abdominal cavity. Both were in extreme conditions of shock when admitted. Ether and normal salt solution under the breasts were started simultaneously and the operation completed as rapidly as possible. It is a waste of opportunity in these cases to wait for the patient to recover from the shock before operating. Shock in these cases means hemorrhage, and the only rational thing to do is to tie the bleeding vessels and do it at once.

Eleven operations were done to correct retro-displacements. In each instance Gilliam's round ligament suspension operation was done. In

doing a Gilliam's operation a short incision is made low down in the median line. The round ligaments are caught up and a strong piece of silk is passed under each one about one inch from the uterus. The fat is then dissected back from above the sheath of the rectus muscle on each side for a distance of about one and a half inches. A small opening about one and one-half inches above the brim of the pelvis and the same distance from the median line is made on each side through the fascia muscle and peritoneum. Through these openings the silk threads under the round ligaments are drawn and by them the round ligaments are drawn through to the level of the fascia and stitched there with catgut. The silk is then removed and the abdominal wall closed.

I have been doing this operation for the past year and a half with the most satisfactory results. So far as I have been able to ascertain there has been but one failure to correct the position of the uterus by this method. In all the others a perfectly movable uterus has been retained in a normal position and all symptoms relieved.

Two vaginal hysterectomies for cancer of the cervix were done. One of these patients had been much reduced by severe hemorrhages from a rapidly growing epithelioma of the cervix; the other was a much more favorable case, having been discovered before much progress had been made.

The vaginal operation was done in preference to the abdominal because the immediate mortality is very much less and the percentage of recurrences no greater. In both cases the broad ligaments were tied off in sections and the pelvis packed with gauze.

The case of vaginal hysterectomy for infection was one upon whom another operator had done an abdominal section and removed the tubes. The abdominal wall was so much scarred from stitch infection that to open it again was not advisable.

The uterus was a bicornate one; the two horns could be clearly felt on either side of the pelvis. The operation was done to relieve the patient of constant pain, which was so great that she was confined to bed. Both horns of the uterus were adherent to the pelvic structures, but there was no especial difficulty in removing it.

One painful cystic ovary about the size of a hen's egg was removed by section through the anterior vaginal wall. This route is preferable

because the patient is able to sooner get out of bed, there remains no visible scar and no chance of a ventral hernia.

The posterior vaginal section for extra-uterine pregnancy did not differ materially from a number of others already reported in the *JOURNAL*. Briefly stated, a posterior vaginal section is indicated in ruptured extra-uterine pregnancy whenever the lost blood is localized. In the majority of these cases the rupture has taken place into the broad ligament.

Posterior vaginal section for pus in the pelvis was done eight times. In one of these cases the abscess was below and behind a large uterine fibroid which extended to the umbilicus. The fibroid will require operation later.

One important part in these operations is to make the examination sufficiently carefully and to discriminate between the cases that can be relieved by drainage and those that are best approached through the abdomen. Whenever there is a collection of pus in the pelvis without reference to its exact location it should be drained. Just how to differentiate between a collection of pus with a thick wall and an ordinary exudate is difficult to describe; but usually it can be done. A long incision is made in the posterior vaginal wall beginning just behind the cervix and extending in the median line. After the vaginal wall is cut through the dissection is carried upward by the fingers. The sac is sometimes so thick that it is necessary to puncture it with the point of the scissors or with a pair of forceps. In either case the opening is enlarged by tearing with the fingers. After the pus has drained out the cavity is packed with a large piece of gauze. When both sides have been opened it is necessary to insert two pieces of gauze. After forty-eight hours about one-third of the length of the gauze should be pulled down and cut off. The remainder should be left four to six days longer. As a rule when this is removed nothing further is necessary. The success of the operation depends upon making a large opening, packing with a large piece of gauze, and not removing the gauze too early.

In twenty-one cases the uterus was dilated and curetted. These were all ordinary cases of stenosis, endometritis or incomplete miscarriage. After the curettement the uterus was thoroughly wiped out with gauze saturated with a bichloride of mercury or lysol solution. Only the

stenosis cases were packed. These were packed not with the ordinary strip of gauze but with a single roll as large as could be forced through the cervix. This was removed in forty-eight hours.

Two cases of cancer of the uterus that were too far advanced for radical operation were curetted and cauterized.

Five operations for repair of the perineum were done. Goldspohn's operation, which is a modification of Tait's operation, was done. A point is selected on each side of the vaginal outlet and secured by bullet forceps. An incision that follows the line of juncture of the skin and mucous membrane is made from one fixed point to the other. The mucous membrane of the vagina is then separated from the underlying structures as far back as is desirable. Nothing is cut away. The torn muscles and fascia are then brought together beneath the elevated mucous membrane by interrupted catgut sutures. The result is a firm supporting structure with no cicatrix in the vaginal wall.

One complete prolapse of the uterus was operated upon. This case should more properly be called a vaginal hernia. The uterus was small and the great prolapsed sac was filled with intestines. The patient was far past the menopause. A narrow strip was outlined leading from the cervix to the vulva on each side. The remainder of the bulging vaginal wall both above and below the uterus was pared with scissors. By repeated layers of interrupted catgut sutures the large surface was closed. The union was good and when the patient left the hospital there was prospect of a permanent cure.

Among the patients operated upon there was one death. This death was due to sepsis. The case was one upon which a hysterectomy with removal of the tubes and ovaries was done for a pelvic infection. The right tube, very much enlarged, passed downward behind the uterus and with the ovary was adherent to the rectum. The rectal wall had been perforated. This perforation allowed a large quantity of pus and feces to pass into the pelvis when the adhesions were broken up. The opening in the rectum was closed with sutures, the pelvis first wiped out and then washed out with salt solution. A large gauze drain completely filling the pelvis was put in. The patient did badly from the first and died in a few days.

NOTE ON THE DISCOVERY AND FIRST USE OF THE
STOMACH TUBE BY AN AMERICAN PHYSICIAN.¹

BY DR. JULIUS FRIEDENWALD, '91,

It is generally believed that two English surgeons, Jukes and Bush, are the inventors of the stomach tube. This claim is based on an article published by Jukes in the *London Medical Repository* of 1822, an abstract of which is found in the *American Medical Recorder* of 1823, entitled,

"Description of an Apparatus for Removing Poisons from the Stomach, Invented by Mr. Jukes, Surgeon."

"We might with justice be considered to be forgetful of the duty we owe the profession, were to fail in laying before them a description of a very excellent apparatus which Mr. Jukes, its very ingenious inventor, favoured us with a sight of. It consists of an elastic gum tube, a quarter of an inch in diameter, and two feet and a half in length, terminating at one extremity in a small globe of ivory, with several perforations; the other extremity is adapted either by screw or by plug (the latter is preferable) to an elastic bottle of sufficient size to contain at least a quart of liquid and having a stop-cock fitted to it, in a similar manner as in the hydrocele bottle. Instead of the bottle, a pewter syringe, of an equal capacity, may be adapted, in the same manner, to the flexible tube. The operation by the syringe is performed more quickly, and may therefore, perhaps, be preferred by some. In cases where surgeons have neither bottle nor syringe, the tube alone might be made to answer the purpose, if the operator apply his mouth to its extremity, and thereby institute the office of a siphon."

"Application.—The patient ought to be placed on the left side, and the globulated end of the tube be then carefully passed to the greater curvature of the stomach, either through the mouth or nostril, as may be thought proper. Having previously filled the bottle or syringe with warm water, at the temperature of 150°, screw or plug it to the tube, turn the stop-cock, and gently force the contents into the stomach. The then diluted contents are to be immediately withdrawn by pulling up

¹From the Johns Hopkins Hospital Bulletin, September, 1903.

the piston; or, if the bottle be applied, the same effect will ensue from its elasticity enabling it to recover its original form, by which the fluid contents will return, charged with the poison. This operation ought to be repeated, till the water, which is withdrawn, becomes clear and tasteless."

"In Mr. Jukes's experiments, first on dogs, and then on himself and others, assisted by Mr. James Scott, Surgeon, in Westminster, the apparatus was proved fully to answer the intended purpose. In these experiments, Mr. Jukes swallowed, first, two drachms of laudanum; he afterwards gradually increased the quantity, until it reached ten drachms; since which he has administered to several individuals (one of them a female) one ounce of laudanum, with an equally successful result. The utility of so well contrived an instrument, arising especially from its being equally adapted to the removal of all the more bulky poisons, must be evident to every one. We consider that Mr. Jukes has rendered an essential service to the profession, and to the community, by its invention."

That the credit of this discovery is due to Dr. Physick there can be no doubt. Physick published his original paper October, 1812, in *The Eclectic Repertory*, Vol. III, page 111, under the title of, "Account of a new Mode of extracting Poisonous Substances from the Stomach. By Philip S. Physick, M. D., Professor of Surgery in the University of Pennsylvania," which is ten years prior to the appearance of Jukes' article. The paper reads thus: "On Thursday, 6th June, 1812, I was sent for in much haste at nine o'clock in the evening, to visit two children of Mr. S. B., each three months old. They were twins, and had been affected with whooping cough for several weeks. The mother informed me that in consequence of her children having been very restless the night before, she had this evening given them some laudanum. To William she had given one drop at seven o'clock, and the same dose to Edmund forty minutes afterwards."

"I found William in a state of stupor or very profound sleep, from which he could not be roused, and was informed that just before my arrival his whole body had been strongly convulsed; his breathing was laborious and his pulse feeble and slow. On inquiry, I found that the

vial out of which the drop of laudanum had been given had contained, several weeks before, nearly one ounce of that medicine, but having been left without a cork, it had dried away so much that one drop only could be obtained for William; in order to procure another drop, two drops of water had been put into the vial and stirred about, by which another drop had been obtained and given to Edmund, forty minutes having intervened between the two doses."

"About a quarter of an hour before my visit, the mother had given to William fifteen drops of antimonial wine, but as it had produced no effect I prescribed an emetic of ipecacuanha, and directed it to be given immediately; this, however, was found impracticable, as the child was incapable of swallowing."

"At half past nine o'clock, Edmund, who had appeared to be in a very easy sleep, became convulsed, and his pulse and breathing were affected in the same way that his brother's had been. We attempted to give him ipecacuanha, but could not make him swallow it. The countenances of the children became livid, their breathing very laborious, with long intervals between the times of each inspiration, and the pulse in each very feeble."

"Under these circumstances it clearly appeared no time was to be lost, and therefore, as they could not swallow anything, I determined to inject an emetic into their stomachs. For this purpose a large flexible catheter was passed through the mouth down the œsophagus into the stomach, and through this one drachm of ipecacuanha mixed with water was quickly injected by means of a common pewter syringe. In hopes that the emetic would operate, I waited some time without any effect being produced. William exhibited now every symptom of speedy dissolution—his face became very livid, the pulse and respiration had almost ceased, and indeed the pulse could not be perceived, except a faint stroke or two, after that kind of imperfect and convulsive inspiration which is commonly observed in children just before actual death, accompanied with a convulsed action of the muscles of the mouth and neck. In this situation I passed the catheter again, and by applying the syringe to its projecting end, drew up the fluid contents of the stomach, and immediately injected warm water, which was again with-

drawn. These operations were alternated two or three times, but when completed no sign of life remained. Hopeless as the case now appeared, I injected some spirit and water mixed with a little vinegar through the catheter; in less than one minute the child again inspired, the pulse became perceptible at the wrist, and in four minutes, with the aid of external stimuli, both went on so perfectly that there was every reason to believe the child would recover. By the time that these operations were performed on William, Edmund was observed to have passed into the same condition of apparent death, from which his brother had just recovered. The same measures were adopted in his case, and with the same happy effect. I now flattered myself that the children would do well, but in this expectation I was disappointed. In about half an hour Edmund's breathing became very slow and laborious, and his pulse, which had before been very much excited, became so feeble that he appeared to be sinking very fast. Supposing that the effects observed might be produced by the spirit which had been given, occasioning intoxication, I determined to extract it from the stomach and to inject warm water, removing it again. This operation was very quickly performed, but at the conclusion of it I was much distressed by seeing the little patient to all appearance lifeless. Observing in this case that the actions of life ceased so immediately after the extraction of the spirit, I determined to try it again, and injected a little weak brandy and water. In less than a minute this occasioned a repetition of breathing and of the action of the heart, and in about five minutes both were regularly performed. The symptoms of ebriety took place also in William, but observing that his brother had been nearly lost by extracting the spirit from his stomach, I did not attempt the removal of it in William's case. Doctor Austin, who kindly assisted me on this occasion, remained all night with my patients. He informed me that after some time they became better through the night. Their bowels were moved several times by castor oil. After five o'clock in the morning Edmund had no convulsions, but they continued with William until twenty-five minutes after nine, when he struggled a little, sighed, and expired. Edmund was troubled for two or three days with a diarrhoea, but soon recovered completely."

"The idea of washing out the stomach with a syringe and tube, in cases where large quantities of laudanum or other poisons had been swallowed, occurred to me at least twelve years ago, and I have constantly, for many years, recommended it in my lectures. In the year 1809 Dr. Dorsey performed the operation of washing out the stomach in such a case, but the patient had taken the poison twelve hours before he was called, so that he did not succeed."

Of interest in this connection is a letter published by Physick in the same volume of *The Eclectic Repertory*, page 380:

"To the Editors of the *Eclectic Repertory*."

"When I sent you the communication published in the first number of the third volume of the *Eclectic Repertory*, descriptive of what I supposed a new method of extracting poisons from the stomach, I was influenced by a desire to propose to my medical brethren a method of treatment which might preserve the lives of many unhappy persons who either by design or accident had swallowed large doses of laudanum or other poisonous substances. If in a single instance I had been instrumental in preventing death, I should have considered myself very happy; and to have withheld a communication which might have been attended with such beneficial effects, would have been in every respect unjustifiable."

"I have the pleasure of announcing to you and to your readers, that in several instances which have recently occurred in this city, the practice has been completely successful. In two cases treated by Dr. Dorsey, in which large quantities of laudanum had been taken, there is great reason to believe that no other mode of treatment would have succeeded in preventing the fatal event. Both patients were saved by injecting warm water into their stomachs, and extracting it again, together with the laudanum, by means of a syringe. I therefore am happy in having called the attention of the profession to a mode of treatment not before used in this country, at least within my knowledge; but I have now an act of justice to perform, in ascribing the merit of the invention to Dr. Alexander Monro, junior, of Edinburgh, who published it in his inaugural thesis, in A. D. 1797. Of this circumstance I was entirely ignorant when I sent you my paper, and probably should still have remained so, had it not been mentioned in his book of *Morbid Anatomy*, a work which has but very lately come into my hands."

"PHILIP SYNG PHYSICK."

"*Philadelphia*, 20th January, 1813."

That the credit of this invention is due Physick is also shown by Mathews in the *Medical Recorder*, Vol. X, 1826, page 325, in an article

entitled "Description of an improved Instrument for Extracting Poison from the Stomach; with some statements tending to establish the validity of Dr. Physick's title to the credit of having invented the Stomach Tube."

"It appears that Dr. Alexander Monro, Jr., in his inaugural thesis, published 1797, suggests the use of a tube and syringe, as a suitable means for extracting poison from the stomach; it does not appear, however, that he ever employed them. About that period, the same plan occurred to Dr. Physick, without having met with the suggestion of Dr. Monro, to whom, however, he subsequently yielded the merit of having made this plan public previous to himself. In the year 1800 Dr. Physick was called to the surgical chair in the University of Pennsylvania, and continued, from that time forward, to inculcate this among other useful inventions with which he has enriched our art, to numerous classes of students, who now constitute a considerable portion of the physicians throughout the union; in proof of this we annex the following certificates, obtained from highly respectable practitioners of this city on another occasion, in order to support Dr. Physick's claim against that of Dr. Thomas Ewell, of the city of Washington, who had the justice publicly to acknowledge Dr. Physick's title upon perusing them. His claim was grounded on his having published, in the *Medical Repository*, of New York, in the year 1808, a paper 'containing a proposition to relieve the stomach from poison by the use of a catheter.'"

"No. 1."

"I do hereby certify, that in the years 1802, 3 and 4, I attended Dr. Physick's lectures upon surgery, and heard him recommend the introduction of a tube into the stomach, in cases where poisonous substances had been taken, through which tube fluid might be injected by a syringe and extracted again; thereby enabling the practitioner to remove such noxious substances from that organ.

Signed, *Philadelphia*, June, 1820,

ISAAC CLEAVER.

No. 2.

"I do hereby certify, that I attended Dr. P. S. Physick's lectures on surgery, in the years 1805, 6 and 7, that, in these lectures, the Doctor exhibited a tube coated with elastic gum, brought by Dr. Dorsey from Paris, and made there by Dr. Physick's order, long enough to reach from the mouth into the

stomach. With such a tube, Dr. Physick advised to inject water or other fluids into the stomach, and draw them back again by the aid of a syringe, in cases where laudanum or other poisons had been swallowed, and thereby to work them out of the stomach and introduce counter agents.

Signed, *Philadelphia*, June, 1820,

JOHN D. THOMAS.

No. 3.

"I remember that, in the winter of 1808-9, Dr. Physick informed me that he had an elastic tube, brought from Europe by Dr. Dorsey, for the purpose of injecting fluid into the stomach, and drawing it out again, in order to wash out poisonous substances, such as opium, &c.

"Signed, *Philadelphia*, June, 1820,

BENJAMIN S. JENNY."

"In the year 1803, Dr. Dorsey was in Paris, and had made, by Dr. Physick's order, a tube of the kind now generally used, constituted of the same materials as the French catheter, and resembling it, except in size. That the use for which it was designed was unknown in Paris previous to that period, is evident from a letter from Dr. Dorsey to Dr. Physick, dated 1803, and now in the possession of the latter, in which he states that the makers were curious to know what was the intention of so large a catheter. It was not long before they ascertained the point, and tubes have since been regularly imported from there, for the supply of physicians in the United States.

"In the year 1809, Dr. Dorsey employed the instrument, but unsuccessfully, as the patient died, owing to twelve hours having elapsed before his arrival. In 1812 Dr. Physick had an opportunity of employing it in a case of twins, to whom the parent had given too much laudanum; one of them died, the other recovered. This case was published in the *Eclectic Repertory* for October, 1812, and has been republished in the second number of the *Medical Recorder* for 1823. Since that period it has proved successful in a great many instances, and has become so common a mode of removing poison from the stomach that almost every physician, even in the country, is furnished with a tube and syringe for that purpose.

"With a knowledge of the foregoing facts, our surprise may readily be conceived, when we heard of the invention being announced in the *London Medical Repository* for October, 1822, as of recent origin, and

claimed for Mr. Jukes, of Westminster. And, also, in the London *Medical and Physical Journal*, for that year, a description of his method by himself, and another modification by Mr. F. Bush, surgeon of Frome, who also claims the honor of the invention. Mr. Bush's mode is the same as that invented by Dr. Physick nineteen years before, namely, a tube and syringe. That of Mr. Jukes differs in having an elastic gum bottle to supply the place of the syringe, which we think no improvement; and his tubes are furnished at the end with an ivory ball perforated with holes, which will be found rather disadvantageous than otherwise, more especially as it is often necessary to pass the instrument through the nose into the stomach, in consequence of the patient proving refractory, and holding the mouth firmly closed, which would be impossible with the ivory ball affixed."

"From the foregoing statement, it will be admitted by every candid individual that the merit of the invention is strictly due to Dr. Physick. It will also be perceived that he was the first to carry it into successful operation."

Dr. Saml. Jackson corroborates this statement in an article in the *American Medical Recorder*, 1823. Referring to Mr. Jukes' work he says: "Whether the early volumes of the *Eclectic Repertory* ever reached the metropolis of England is rendered doubtful, since we find, from the last numbers of the *Medical Recorder* and of the *Journal of Foreign Medical Science*, that some of the writers of that city have claimed the invention of a new method of washing and extracting poisons from the stomach, by means of a tube and syringe, for their fellow citizen, Mr. Jukes. 'We might with justice,' say they, 'be considered as forgetful of the duty we owe the profession, were we to fail in laying before them a description of a very excellent apparatus which Mr. Jukes, its very ingenious inventor, favored us with a sight of.'

"We are entirely willing to grant Mr. Jukes all the credit the journalists would claim for him or he claim himself, as the same thought might have occurred to many ingenious men, who were seriously engaged in relieving the distresses of suffering humanity. But the priority of discovery and the demonstration of its great utility must certainly be awarded to our countryman, Dr. Physick.

"I well remember the satisfaction that Dr. Physick's operation afforded in Philadelphia, and that the invention of it was cordially ascribed to himself. But now, after a lapse of ten years, we find it claimed by the editors of the *London Medical Repository* for Mr. Jukes, surgeon in Westminster. How much was I surprised in reading their account of it when, at the same time, I could look over my shoulder to a box containing a large syringe with Physick's elastic tube, two feet long and a half inch in diameter, an apparatus that has occupied that station for the last nine years. It is true that our American tubes are not tipped with an ivory globe, an addition which I cannot but consider as wholly useless."

There can be no doubt from the foregoing that Dr. Physick used the tube as early as 1800 and that he recommended it for many years in his lectures to his students; that by his advice his nephew Dorsey had stomach tubes made in Paris as early as 1803 and employed the tube unsuccessfully in a poisoning case in 1809; and that in 1812 Physick published the report of successful results with its use in cases of poisoning. The work of Jukes first appeared in 1823; there can, therefore, be no doubt but that Physick was the inventor of the stomach tube and was the first to make practical application of this instrument.

NOTE.—The reference made by Dr. Physick and others to the invention of the stomach tube by Alexander Monro, Jr., refers to Monro's Inaugural Thesis, published in 1799. Monro merely suggests the use of the tube in cases of poisoning for the extraction of the poison from the stomach and for the introduction of food into the stomach in cases of dysphagia and for extracting gases and food from the stomach in cases of gastric fermentation in cattle. He does not point out, however, that any practical application of the tube was made in cases of poisoning.

PATHOLOGY OF SMALLPOX.*

By DR. WM. ROYAL STOKES.

PATHOLOGY.

A number of interesting changes have been noted in the various tissues and viscera of smallpox cases, and these changes are widely distributed throughout the system.

*From the Laboratory of the State and City Boards of Health and the Pathological Laboratory of the College of Physicians and Surgeons, Baltimore.

The pustular eruption is frequently found on the surface of the mucous membrane of the respiratory tract, and these often coalesce as ulcers, or masses of fibrinous inflammation.

These pustules and ulcers are often seen in the bronchi of the third and fourth order, and are quite frequent at the bifurcation of the bronchi. Necrosis of the surface epithelial cells is also very frequent, and fibrinous and purulent inflammation is also often present.

The lung often contains areas of broncho-pneumonia, and the liver, the kidney and the heart muscles show cloudy swelling and fatty degeneration. The heart muscle also often exhibits fragmentation of the fibres. The acute, soft, splenic tumor of infection is usually present.

An interesting set of changes has been described by Weigert,¹ consisting in areas of local necroses in the liver, spleen, kidney and lymph glands. These areas consist of degenerated masses of coagulative necrosis containing much nuclear detritus, and many degenerated cells without nuclei.

The lesions of the bone-marrow first described by Chiari,² and called "osteomyelitis variolosa," are said to occur in 72 per cent of all cases. These small scattered nodules are about the size of a pea, and under the microscope they consist principally of epithelioid cells, which are probably produced from the normal marrow cells by proliferation. Leucocytes and traces of fibrin are also present, and the masses often undergo coagulative necrosis.

Chiari examined the bone-marrow of 22 cases of smallpox in various stages with the following results: During the stage of simple early eruption, he investigated five cases, and found microscopic changes in three instances. Nine cases were observed in the pustular stage, of which eight gave positive results. Eight cases were examined in the stage of healing or scaling, and all gave positive results. In one of two cases who died from other causes about two months after recovery from smallpox, these necrotic masses were found.

The process is found especially in the yellow marrow of such bones as the femur, tibia, ribs, sternum, and the body of the vertebræ, and begins by a proliferation of the normal marrow cells. These form masses of cells, whose nuclei are surrounded by much cytoplasm. A

few neutrophilic leucocytes are also found in these masses of epithelioid cells, and they soon show a central area of necrosis which often contains fibrin. He only demonstrated micrococci in one case as present in these necrotic masses.

Similar areas are frequently found in the testicle, and this condition is called "orchitis variolosa." In the hemorrhagic smallpox the above changes are usually present in combination with local hemorrhages in the skin and various serous cavities.

CHANGES IN THE SKIN.

The first change, according to Unna,^{*} consists in an edema and swelling of the epithelium. Many of these cells undergo softening and colliquation, forming a cavity, while others remain as septa, dividing the cavity up into smaller loculi.

The epithelial cells undergo a special degeneration which is known as ballooning, and which affects all of the various layers, even penetrating into the hair follicles. These swollen cells often attain from two to three times their normal size. They sometimes retain their nuclei, but the cytoplasm becomes perfectly clear, and the nuclei are often fragmented. It is a variety of coagulative necrosis. Sometimes two or three nuclei are present in one cell.

The epithelial cells continue to undergo liquefaction, and this causes an increase in the size of the cavity, at the same time mitoses are found in the cells forming the circumference of the cavity. The cells become compressed, and undergo fibrinoid degeneration, forming strands in the cavity which give the reaction for fibrin.

Umbilication is explained by the fact that the degeneration and edema of the epithelial cells take place more at the periphery of the vesicle. The less swollen centre remains behind. Unna does not believe that the cords of the compressed epithelial cells running through the vesicle act as guy ropes, but that the edema and compression is exerted more at the sides of the vesicle, and thus this portion of the lesion extends beyond the less compressed centre.

In the vesicular stage an exudation of serum takes place, and neutrophilic leucocytes also emigrate from the vessels into the vesicle form-

ing the pus of the vesicle. These infiltrate the cutis, and also soon fill the vesicle, producing the pustular stage of the disease. This primary invasion of leucocytes is due to the smallpox poison, but often at the end of the first week there is a second leucocytic invasion, due to a secondary infection with the pyogenic cocci.

HEALING.

As the pustule begins to dry, a scale or crust is formed, and the lesion is invaded by sprouting projections of newly-formed epithelial cells. The upper layers become horny, the lower layers form the other normal cellular layers. In order not to form a scar, the newly formed epithelial cells must grow in an even layer with the convex surface downward, and the stratum Malpighii must not have been destroyed by the process of degeneration.

PLASMA CELLS.

There is one change which should be mentioned in this connection, and that is the appearance of the plasma cells in the corium. It is held by many that the injury caused by the poison to the epithelial cells is the very first change which is apparent. Dr. Gilchrist, however, has kindly loaned me some sections made from very early papules, and although the epithelial cells show little or no changes, the cutis shows a marked infiltration with plasma cells. These are usually collected about small arteries and capillaries.

Dr. Gilchrist is of the opinion that this plasma-cell invasion is the earliest change to be noted in smallpox, and this opinion accords very well with the best conception of the method of infection.

It is inconceivable that the poison comes in contact with every portion of the skin at practically the same time, thus causing infection. It seems more rational to believe that the cause is inhaled and that by means of the circulation it reaches the skin, where it causes widely distributed lesions. The primary exudation of the plasma cells from vessels followed by the various epithelial lesions supports this theory.

PATHOLOGICAL STUDY.

The following pathological study was made from a series of five autopsies performed during the past year, and from sections and cultures in six non-fatal cases.

All of the cultures in the non-fatal cases were made from vesicles or early pustules, and in every case they remained sterile. Five sets of cultures were made from the autopsies, and in all of these cases the condition had advanced well into the pustular stage. Four cases gave a pure growth of the streptococcus pyogenes from the pustules, and one case of hemorrhagic smallpox showed the presence of the staphylococcus pyogenes aureus.

Various attempts were made to cultivate the specific cause of the disease. Material from bacteriologically sterile pustules was inoculated into eggs, on the surface of coagulated egg albumen, and in 1 per cent sterile milk, as this is said to be a good nutrient material for amebæ. All of the results were negative.

PATHOLOGICAL CHANGES IN SMALLPOX.

In two of the five cases the respiratory tract was the seat of extensive changes. The inner surface of the larynx and trachea were both almost entirely covered with a dirty yellow pseudomembrane. The under surface of the epiglottis was also involved.

HISTOLOGICAL CHANGES.

The primary condition consisted in an extensive degeneration of the lining epithelium. Often the limiting membrane of the nucleus was destroyed, and the chromatin was scattered as a fine dust through the cytoplasm, showing the condition known as nucleorhexis. Hyperchromatosis and irregularity in the size and shape of the nuclei also existed. These changes result in complete granular necrosis of the epithelium, and cause a necrotic layer without fibrinous deposits.

The submucous coat is often separated from the mucous coat by an exudation of fibrin and serum, and the former coat, together with the muscular coat, are richly infiltrated with plasma cells, small lymphocytes and cells resembling epithelioid cells. Even the cartilage cells show changes, consisting in the disappearance of the cytoplasm of the cell. The cell often forms an empty vacuole, with the nucleus forced to one side.

Streptococci in great numbers were stained in the masses of superficial necrotic cells, and in the vessels of the submucous coat.

LUNGS.

The pleural surfaces of one case were dotted by vesicles about the size of a number six shot. These were very numerous, and on microscopic examination they seemed to be large lymph spaces distended with a serous fluid. One case showed a fibrinous pleurisy, and in three cases broncho-pneumonia existed.

In two of the cases the typical necrotic areas existed, which are so characteristic of smallpox. These consisted of a central area of coagulative necrosis containing numerous groups of streptococci. The necrotic centres were surrounded by a zone of cells, consisting of small lymphocytes, proliferated alveolar endothelial cells, and a few leucocytes. Both the necrotic area and the surrounding cells show masses of nuclear fragmentation, and many of the cells simply form a mass of granular debris.

The presence of actual bacteria in such large numbers in local necrotic areas is a departure from the usual rule, as in typhoid fever, eclampsia, diphtheria, and other diseases showing these changes, the bacteria are not present necessarily, and the change is probably due to the toxin, or mechanical effects of cellular or fibrinous thrombi.

HEART MUSCLE.

Histological Pathology.

In three cases the nuclei of the cardiac muscular fibres showed great irregularities in size, many being small and shriveled. Others were enlarged, irregular, oval or round, and stained more lightly than normal. In one case there was evidence of longitudinal splitting of the fibres, on cross section a central channel, containing radiating smaller connecting lines resembling a fine tooth comb, being present.

THE LIVER.

The livers in all cases were enlarged and yellowish, but very little fatty change was found microscopically. Cloudy swelling, the accompaniment of all acute infections, was always present. Under the microscope the enlargement was found to be due to congestion and cloudy swelling, and no fatty areas were seen. In one case a few collections of proliferated endothelial cells and small lymphocytes were present without actual gen-

eral necrosis, and in another case necrotic areas, somewhat similar to those described in the lung, were detected. These two different varieties of necrosis of the liver correspond to those described by Councilman ' and Mallory in their studies of the liver in diphtheria. The first variety they called disseminated necrosis, and these usually only consist of a collection of cells of various types. The liver cells present are necrotic and broken down, and the nuclei showed various stages of degeneration.

Among the necrotic liver cells a few proliferated endothelial cells and leucocytes are usually found.

Although these changes were only made out in the liver of one of the five cases, the degeneration of the liver cells and the proliferation of the endothelial cells could be made out in these small areas, which in this particular case usually consisted of about twenty-five cells.

In one case, that of a child two years old, the so-called central necroses of Councilman and Mallory were detected in the liver. These usually occur near the central vein in diphtheria, but in the one case of smallpox they were found in connection with the portal systems, and even in the middle of the lobules. They simply consisted of large collections of broken down necrotic masses of a homogeneous material resulting from the destruction of liver cells. These areas took on a brilliant red stain when treated with methylene blue and cosin. The necrotic areas are marked by large collections of nuclear detritus, and the destruction of liver cells can be well made out on the edge of the areas. The protoplasm of the cells coalesces into homogeneous masses, and in the early stages of destruction the chromatin of the nucleus breaks up into large irregular fragments, which are scattered through the cytoplasm of the cells. This was in a case of general streptococcus infection, but streptococci did not seem to play any important part in the production of these areas as particulate bodies. A few streptococci were found on the edge of these areas, but they were not detected in the middle of the necrotic material. Throughout the rest of the liver large groups of streptococci were found in the capillaries and spaces between the endothelial cells and liver cells. It would seem, therefore, that excluding the cause of smallpox, that these areas are caused by the soluble products of the secondary invader, the streptococcus pyogenes.

MICROSCOPIC EXAMINATION OF THE KIDNEYS.

Extensive changes were found in every kidney examined.

In one case the acute interstitial nephritis, described by Councilman⁶ in cases of scarlet fever and diphtheria, was found. The kidneys were enlarged, and the tubules were separated from each other by cellular infiltration. This infiltration also surrounded the glomeruli outside of the capsule. These cells are not leucocytes, but are much larger, and the nucleus stains very deeply and is usually placed excentrically at either end of the cell. Councilman believes that in some way these cells are derived from the small blood vessels, as they are often found within these vessels. He also thinks that their irregular shapes indicate that they are ameboid, and he identifies them as Unna's plasma cells. According to him they are large lymphocytes, and they emigrate from the vessels in acute interstitial inflammation of the kidney. They are very numerous in the spleen and bone marrow, and are probably found principally in these situations.

In one very malignant confluent case the kidney was the seat of most interesting lesions.

On looking at some of the glomeruli, with the low power, they seem partially changed into hyaline masses, and the high power shows that this condition is due to numerous large or small droplets of a clear hyaline material within the lumen of the capillaries. This condition is apparently due to an actual degeneration of the endothelial cells of the glomerular capillaries, since many of these can be seen in the various stages of degeneration. The nuclei seem to swell and take up a much paler stain than normal, and the cytoplasm breaks up into round hyaline droplets of various sizes, which often coalesce into large confluent drops, apparently obstructing and distending the capillary lumen.

Sometimes the chromatin of degenerating endothelial cells becomes increased in amount and granular.

The epithelial cells lining the capsular space also frequently proliferate, which compresses the capillary network into an irregular mass. They can be distinguished from the endothelial cells of the capillaries by their larger vesicular more lightly staining nuclei, and by the greater amount of eosin-staining cytoplasm. These proliferating capsular endothelial cells show a great tendency towards hyaline degeneration, which

seems to begin by an increase in size of the nucleus, while the cytoplasm turns to round hyaline drops of various sizes. The nucleus takes on a paler stain with hæmatoxylin, and finally disappears in the hyaline material, which becomes confluent, forming large round or oval drops.

Sometimes the hyaline material forms a large crescentic mass of homogeneous clear material in the capsular space.

The epithelium of the convoluted tubules is swollen, and the cytoplasm of the cells contains numerous granules. Many of the cells, however, have undergone a much greater change. The cytoplasm is completely transformed into a mass of clear droplets of about the average size of from three to ten times the diameter of a micrococcus. The nuclei are usually well preserved, although the cells are often swollen to about twice their natural size, and simply consist of a mass of granules. These degenerated cells finally break up and the granules become free in the lumen of the tubule. Here they seem to coalesce into hyaline casts. The limbs of Henle are often distended and filled by casts of clear hyaline material. These areas of degeneration do not stain by Van Gieson's stain, and are therefore not true hyaline. When stained by Weigert's fibrin stain, however, both the clear droplets and the casts take up a deep purple stain. This is the reaction for fibrin, and the degeneration must be of a fibrinoid character. The formation of the hyaline casts from the degenerated cells can also be clearly made out, as many purple droplets are seen gradually coalescing to form casts taking the same stain. This is of interest concerning the somewhat doubtful origin of hyaline casts, and it would seem clear that in this instance they were formed from degenerated cells of the tubules undergoing fibrinous change. The formation of casts from somewhat similar large droplets has been described by Councilman and Mallory in diphtheria. These large droplets in the degenerated tubular epithelium of the cortex stain a deep blue color by Mallory's connective tissue stain, and the hyaline casts present stained also blue by this stain. Councilman and Mallory think that both the hyaline and granular casts are formed from these products of cell destruction.

When these degenerated cells are stained by osmic acid, and then counterstained by safranin, eosin or other stains, many of the smaller granules take up the black fat stain, but many remain colored by the safranin or eosin.

There are therefore fatty and fibrinous changes side by side in the same cell.

CHANGES IN THE SPLEEN AND OTHER VISCERA.

The spleen was large and soft in two cases, and of normal size and consistency in three instances. Microscopically, nothing was found except acute congestion of the splenic spaces. The stomach, small intestines, large intestines, bladder, diaphragm, voluntary muscles, and pancreas were normal in those cases examined. The granular layer of the medulla of the adrenal gland in one case contained areas of cellular infiltration without necrosis. These consisted of small lymphocytes and cells of an endothelial type.

LESIONS IN THE SKIN.

No lesions of the skin were noted which have not been previously described, but the primary exudation of plasma cells has not been especially emphasized in Unna's description. These plasma cells are probably derived in part by proliferation from the endothelium of the lymph spaces and lymph vessels.

In the hemorrhagic case, the cells of the stratum granulosum showed various stages of nuclear degeneration, and the edema of the cytoplasm with typical ballooning was observed. The capillaries and lymph spaces of the corium were greatly distended by red blood corpuscles, and numerous hemorrhages were present in the connective tissue. The epidermis was not invaded by red blood corpuscles.

CHANGES IN THE TESTICLE.

Necrotic changes were noted in the testicle in two cases, and the various stages could be well traced out. The process seemed to begin by a necrosis of the epithelial cells of the seminiferous tubules. The nuclei of these cells showed marked karyorhexis, and the protoplasm of the many cells was necrotic and granular. In the later stages, large areas of necrosis can be seen to particularly consist of seminiferous tubules which have coalesced into masses with central areas of coagulative necrosis, with nuclear fragmentation, surrounded by a thick zone of necrotic cells. The intertubular connective tissue is thickened, and even the walls of the arteries have undergone necrosis with nuclear fragmentation.

SECONDARY BACTERIAL INFECTION.

This is a point of general importance, as the rapid advance of serum therapy towards a remedy for combating septicemia bears directly upon this matter.

It is now well known that many typhoid cases, and perhaps the majority of the eruptive fevers, die not so much from the primary cause, as from secondary infection with the streptococcus pyogenes.

This streptococcus infection is the most striking feature of fatal smallpox, and the course of infection can be traced from the skin to the general circulation.

As mentioned above, the cultures from vesicles in early and mild cases of smallpox remained sterile, but after the secondary fever the pustules often contained streptococci in abundance.

Four of our fatal cases contained streptococci in the pustules, and various viscera, such as the heart, liver, kidney, spleen, lymph glands, pancreas and lung. One showed a general infection with the staphylococcus pyogenes aureus.

On staining by Weigert's stain for bacteria, streptococci could be demonstrated in the pustules of the skin, and in the lymph spaces of the corium.

From this point they are carried to the lymphatic glands by the lymph current, and stained sections from the cervical and bronchial glands gave a remarkable picture.

In the cortex of the glands, usually just beneath the capsule, there were extensive focal necroses. The lymph-sinuses were greatly distended, and the necrotic areas often contain neutrophilic leucocytes. When these glands are stained by Weigert's method, many of the necrotic areas are seen to consist almost entirely of masses of streptococci. There are also many streptococci in the lymph sinuses of the glands. The arteries and capillaries also contain streptococci, and there are fibrinous thrombi in many of the lymph channels of smaller glands. This condition was found in the cervical and bronchial glands, showing the absorption of streptococci from the pustules of the skin, and the diseased mucous membrane of the bronchus.

These organisms then enter the general circulation, causing general septicemia, and bacteria were demonstrated in stained sections from the kidney, liver, lung, and testicle. The bacteria were in the necrotic areas of the lung, and also in the interlobular capillaries of the kidney, the lymph spaces of the portal system, the capillaries of the liver, the perivascular lymph spaces of the lung, the necrotic epithelium of the bronchi, and the veins and lymph spaces of the thymus gland, which also contained thrombi. The presence of the pyogenic bacteria in the skin and lymphatic glands has already been mentioned.

Ewing⁶ found streptococci in the heart's blood in 29 cases of small-

pox, and Arnaud⁷ obtained this organism in two cases from the blood of the heart during life.

TENDENCY TOWARDS GENERAL THROMBOSIS.

Many of the viscera contain fibrinous thrombi in the small blood vessels and lymphatics, and these lesions are usually very pronounced in the blood vessels of the lung, spleen and lymphatic glands. Large masses of fibrin are very frequent in the vessels of these viscera.

SUMMARY.

Although we have only studied five cases of smallpox, yet some conclusions can be drawn from the work.

The early skin lesions indicate that the primary infection in smallpox takes place in the lungs, probably by inhalation. The poison, when it enters the circulation, shows a selective influence on the epithelium of the skin and respiratory tract, and many cases are probably not further affected.

The serious and fatal lesions of smallpox are caused by the secondary infection from the skin and respiratory tract, and the infectious agent is usually the streptococcus pyogenes. This organism is so distributed throughout the lesions as to explain most of the visceral changes, such as local necrosis, and the various pulmonary changes.

This streptococcic septicemia is the most striking feature of fatal smallpox, and if it were possible to overcome this condition by a special serum, the mortality from the disease would be greatly reduced.

LITERATURE.

1. Weigert: Anatomisch. Beiträge z. Lehre v. d. Pocken. Heft 1. Breslau, 1874.
2. Chiari: Zeitschrift f. Heilkunde. Bd. VII, S. 385; Beiträge z. path. Anatom. und allgemein. Path. Ziegler. Bd. XIII, S. 13.
3. Unna: Die Histopathologie der Hautkrankheiten. Berlin, 1894.
4. Councilman: Journal of the Boston Society of Medical Sciences. Vol. V, No. 5.
5. Councilman: Journal of Experimental Medicine. Vol. III, Nos. 4 and 5, 1898.
6. Ewing: Transactions of Association of American Phys., 1902, p. 208.
7. Arnaud: Rev. de Med., 1900, p. 303.

OTHER LITERATURE.

E. Wagner: Archiv f. Heilkunde. Bd. XIII. Immerman. Nothnagel's specielle Path. und Therapie. Band IV, No. 2.

WILLIAM S. GARDNER, M. D., EDITOR,
6 W. Preston Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER.
Mt. Washington.
Telephone, C. & P., Tuxedo, 984.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE

THE OPENING OF THE SESSION.

As we go to press we are aware of the fact that we are on the eve of another session. Things have taken on an air of work and students are coming back, and the prospects for a large class are better than they have been for some years. There are already many more registered than there were at the same time last year. This is the season of the year when one feels most energetic, and it is a pleasure alike to student and teacher to get into the harness of college work again. We shall both be ready and anxious to throw it off again at the close of the session.

It is a pleasure to see the old faces fill up the lecture hall and to note that the pale, white face of April has turned to a ruddy brown in October. The worn-out student who leaves in the spring looking like he had been through a trying ordeal comes back rejuvenated and so full of life and spirits that it may even be a task to keep him in line.

This year the College begins the thirty-second year of its work. Every year sees some change for the better, and this year we are glad to say that there will be considerable additions made to the City Hospital, which of course means more clinical material for the student. The houses above the College on Courtland street have been secured and will be remodeled for many necessary additions to a large hospital.

The session opened on the first of October, and the annual address of welcome was delivered by Professor Dobbin. The subject of his address was "The History of Obstetric Teaching in America."

THE PLAINT OF THE TREASURER.

According to Dr. Brack, the treasurer of the JOURNAL, life is not a glorious sunset, at least not all of it. With his ever-watchful care he manages somehow to keep the JOURNAL out of debt, but only by saving at every turn. This summer it was necessary to remind the subscribers that many of them had not yet settled their accounts, so little suggestive reminders were inserted in each number of the JOURNAL as it left the hands of the printer. We thought that those who had paid would understand that the suggestion did not apply to them, and we did not think that they would want us to pick out of the two thousand that are sent their particular JOURNAL and take out the slip.

Imagine then the surprise of the good treasurer when he found in each mail loud cries from the virtuous who had paid their dollar. They accused him of trying to extort money from the needy, of embezzling, of having a desire to take a trip to Canada, and of many other things which the modesty of our editorial column forbids our even alluding to. The hard-worked, unpaid, much-maligned, but fortunately much-more-beloved Brack is still with us and we take this opportunity to remind you all who have not paid for the JOURNAL that we cannot pay the printer and the postage if you don't pay your subscriptions. And to those who have paid promptly we extend our thanks and assure you that we appreciate it very much.

DEATH OF DR. JOHN R. KIMERER, '85, AT DANVILLE, PA.

The citizens of Montour county were very much startled upon the morning of July 1 to learn the sad news of Dr. J. R. Kimerer's sudden death. The doctor was about his professional duties apparently in the best of health, retiring the night of June 30, after a hard day's work, with plans laid for the morrow. Early in the morning the doctor was found in bed by his daughter dying; death closed the scene before aid could be summoned. Dr. Kimerer was born in Nashville, Ohio, on September 2, 1859; was therefore 43 years of age. He was graduated at the College of Physicians and Surgeons, in Baltimore, in 1885. In 1886 he came to Danville and launched into the practice of medicine.

His social qualities, together with his success as a practitioner, made him very popular and in the course of a short time built up a large practice. Dr. Kimerer was twice married. In addition to his wife, he is mourned by two children of his first marriage to whom he was most affectionately devoted. The doctor was an earnest and active member of the Montour County Medical Society, as well as the State Medical Society. For a number of years he has been secretary of the local society, always interested in its welfare and ever ready to advance its usefulness. He was a member of the Danville Board of Health for several years.

In his death the community loses a good citizen and a kind, sympathetic physician.

C. S.

Personal Notes

DR. HARRY FRIEDENWALD, '86, spent July and August in Europe. He was a delegate to the Zionist's Congress in Switzerland, and spent his leisure in climbing mountains.

DR. J. GORSE SIMMONS, '91, delivered an address on "One Characteristic of the Great War President" at the Memorial Day services at the Methodist Episcopal church at Westchester, N. Y.

DR. HARVEY G. BECK, '96, was married to Miss Katherine Elizabeth Clagett, of Blairsville, Pa., September 23. Dr. Frank Dyer Sanger was best man. They will live in the house recently purchased by Dr. Beck, 214 E. Preston St.

DR. B. B. HUDSON, '97, who is now practicing in Americus, Ga., is at the College doing some post-graduate work. He has been at the New York schools and comes to Baltimore with the conviction that Alma Mater is good enough for him.

DR. A. W. MACMILLAN, '03, is located at Charleston, W. Va., and is doing well. He has been elected a member of the State Society and of the Kanawha County Medical and Surgical Society. Before the latter he recently read a paper entitled "The Value of Routine Examination in Diseases of the Chest."

DR. LEWIS H. GUNDRY, '90, has purchased the Conrad Sanitarium, established by the late Dr. J. S. Conrad at the Relay Station in 1878. The location is one of the most beautiful in Maryland, and is admirably adapted to its present use. Cases of nervous and mental disease, alcoholic and drug addiction, prostration from overwork, and convalescents from severe illness are treated.

WANTED:—Recent graduates in medicine to act as solicitors for old line life insurance companies in the State of Maryland. The undersigned has had applications for young men who can add to their incomes by this work, and not interfere with their professional duties. He will be glad to assist any who may wish such an opportunity.

DR. WILLIAM J. TODD,
Mt. Washington, Baltimore Co., Md.

DR. FRANK DYER SANGER, '88, and DR. JOHN RUHRÄH, '94, spent July and August in England, Scotland and Wales making a tour of the English cathedral towns and the English and Scotch lakes. They attended the meeting of the British Medical Association, which was held this year in Swansea, Wales. Dr. Ruhräh read a paper before the Section on Diseases of Children on "The Relation of the Thymus Gland to Marasmus."

We are in receipt of a well printed, nicely bound volume entitled "My Child and I." It is from the pen of the wife of one of our graduates, which gives it a great interest in our eyes, but which it would merit for itself. The author is Mrs. F. L. S. Aldrich, M. D. who is the wife of Dr. A. G. Aldrich, '79. The doctor and his wife have offices in Minneapolis and also at their country home, Anoka-on-the-Mississippi. The book deals with the life of the child in sickness and health from the time of conception up to sixteen years of age. It is written in a style that should make it comprehensible to the laymen for whom it was intended. It also gives suggestions for the mother during her pregnancy and puerperium. There are chapters on the more common diseases of infancy and childhood and many useful pointers on the nursing and the treatment of the little patients.

KRESGEVILLE, PA., July 22, 1903.

CHARLES EMIL BRACK, M. D.

Dear Doctor.—Enclosed please find my check for two dollars as payment to ALUMNI ASSOCIATION JOURNAL. It is always received royally. I am still located where I first put up my shingle to the breeze. Would be pleased to have you report all of class '91. Yours truly,

D. C. TRACH, M. D., '91.

MILLVILLE, PA., July 16, 1903.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—I have neglected to subscribe for the ALUMNI JOURNAL before, but will now send you check for this year before I forget it again. I graduated in the class of '87 and came to Millville, Pa., and have been located here ever since. I am always glad to receive the JOURNAL and look over the personal notes to see if there is any news from the boys who graduated in 1887. Respectfully yours,

H. S. CHRISTIAN, '87.

YORK, PA., July 16, 1903.

My Dear Brack.—Inasmuch as we are taught that the "Lord loves a cheerful giver," and likewise that "a fool and his money doth soon part," I take this occasion to pay my subscription to the ALUMNI JOURNAL. With best wishes for you and regards to all the boys, I am,

Cordially and fraternally yours,

F. J. SNYDER, Class of '87.

409 S. George St., York, Pa.

MELROSE HIGHLANDS, MASS., August 15, 1903.

Dear Doctor.—You will please find enclosed a check for \$2.00 as payment for the ALUMNI JOURNAL for the years 1902 and 1903. I wish to say that I am very much interested in the old College and the "boys" and your JOURNAL, but I am so very busy with my practice, and a rather large family, that I have no time to correspond with anyone.

Very truly yours,

M. B. RAYNES, '96.

READY BRANCH, N. C.

CHAS. E. BRACK, M. D., Baltimore, Md.

Dear Sir.—Enclosed find one dollar as per statement for the ALUMNI JOURNAL. I belong to the class of 1893. I located a while at Purlear, this State, then came to this place. I am doing a general practice in the country. I hope to be able to visit the old College this winter.

Yours very truly,

DR. ALBERT J. ELLER.

Ready Branch, Wilkes Co., N. C.

WISHAW, PA.

Dear Dr. Brack.—It was with much pleasure that I read the July number of the JOURNAL, which you so kindly sent me. I enclose a money order of \$1 for the year's subscription ending April, 1904. Would you kindly send me one of last April's number?

I am located at the above place at present. Am with Dr. Free, and will probably be in this country for quite awhile. I feel very much at home up here. We have quite a number of P. & S. men here. Drs. Free, Blaisdell, Williams, Hughes, Clark, McKay and Graves are all in this locality. I took my State Board in June at Pittsburg. The only other P. & S. man to take it there was Beck. We were both lucky enough to make it. I met quite a number of Fraternity men at Pittsburg. They treated me royally. There were Phi Beta men from five chapters taking the examinations.

Please remember me kindly to all my old teachers and friends around the College.

Hoping you are enjoying the nice warm weather which I hear you are having in Baltimore, I am,

Very sincerely yours,

EDGAR B. FRIEDENWALD, '03.,

Address, Adrian Hospital, Punxsutawney, Pa.

N. B.—McKay, '01, was married to Miss Jenks, of Punxsutawney, on June 17 last. They live at New Florence.

ANTIDIPHThERITIC SERUM

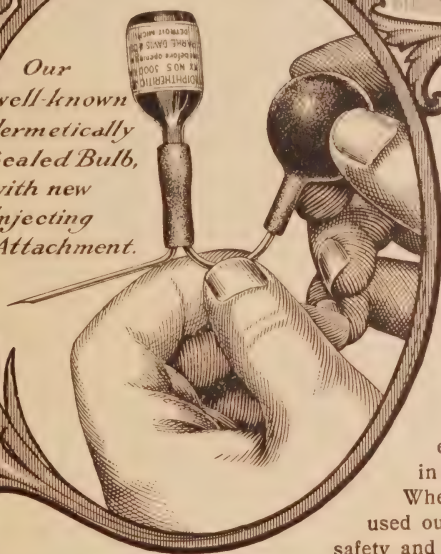
PARKE, DAVIS & CO

TWO NEW DEVICES
FOR ITS ADMINISTRATION.



*New Bulb Syringe,
with Sterile
Needle.*

*Our
well-known
hermetically
sealed Bulb,
with new
Injecting
Attachment.*



SIMPLE APPLIANCES

AND QUICKLY
OPERATED.

In either of these de-
vices the physician has
an efficient, sterile in-
strument, with which a
strictly aseptic injection
can be given.

Full directions with each package.

We are the largest produc-
ers of Antidiphtheritic Serum
in the world.

Wherever diphtheria antitoxin is
used our product is esteemed for its
safety and potency.

During all the years of our work as biological manufacturers not one
untoward result has followed the use of our Antidiphtheritic Serum.

NOTE.—On unspecified orders our Antidiphtheritic Serum is supplied in the hermetically sealed glass bulbs which
have long had the confidence of the medical profession. Each bulb is accompanied by the new Injecting Attach-
ment designed by Dr. Jacques of the Chicago Board of Health. This device (which the physician may use or not,
as he chooses) is by far the simplest of the kind yet offered to the profession.

PARKE, DAVIS & COMPANY

LABORATORIES: DETROIT, MICH., U.S.A.; WALKERVILLE, ONT.; HOUNSLOW, ENG.

BRANCH HOUSES: NEW YORK, CHICAGO, ST. LOUIS, BOSTON, BALTIMORE, NEW ORLEANS, KANSAS
CITY, MINNEAPOLIS, INDIANAPOLIS, MEMPHIS; LONDON, ENG.; MONTREAL, QUE.;
SYDNEY, N.S.W.; ST. PETERSBURG, RUSSIA; SIMLA, INDIA; TOKIO, JAPAN.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
J. W. CHAMBERS, M. D., Professor of Anatomy.
WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
R. BAYLY WINDER, Phar. G., D. D. S., Materia Medica.
EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
J. N. FARRAR, M. D., D. D. S., Irregularities.
DR. GEORGE EVANS, Crown and Bridge-work.
KASSON C. GIBSON, New York, Oral Deformities and Fractured Maxillaries.
JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S.....Ohio.
E. PARMLEY BROWN, D. D. S.....N. Y.
A. L. NORTHPROP, D. D. S.....N. Y.
E. L. HUNTER, D. D. S.....N. C.
W. W. WALKER, D. D. S.....N. Y.
OSCAR ADELBURG, D. D. S.....N. J.
G. MARSHALL SMITH, D. D. S.....Md.
C. M. GINGRICH, D. D. S., Resident.....Md.
R. B. DONALDSON, D. D. S.....D. C.

H. A. FARR, D. D. S.....N. Y.
J. EMORY SCOTT, D. D. S.....Md.
C. L. ALEXANDER, D. D. S.....N. C.
M. M. MAINE, D. D. S.....Conn.
J. W. DAVID, D. D. S.....Texas.
A. C. BREWER, D. D. S.....Md.
J. ROACH, D. D. S.....Md.
J. HALL MOORE, D. D. S.....Va.

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

WILLIAM G. FOSTER, D. D. S. GEORGE D. HARDY, M. D., D. D. S.
EDW. HOFFMEISTER, Ph. D., D. D. S. W. W. DUNBRACCO, D. D. S. GEO. V. MILHOLLAND, D. D. S.
L. M. PARSONS, D. D. S. H. M. LEVER, D. D. S. C. R. STEWART, D. D. S.
J. K. BURGESS, D. D. S. J. C. SUTHERLAND, D. D. S. CHAS. THEBERATH, D. D. S.
HARRY E. KELSEY, D. D. S. C. H. CARSON, D. D. S. C. S. GORE, D. D. S.
L. F. PALMER, D. D. S. L. D. CORIELL, D. D. S. A. C. HARRISON, M. D.
S. B. GRIMES, M. D. S. G. DAVIS, M. D.

The Sixty- Fourth Annual Session will commence on the 1st of October, 1903, and continue until May, 1904.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD

SOMNOS

(Chloraethanal Alcoholate)

A safe and reliable HYPNOTIC and CEREBRAL
SEDATIVE, free from depressing effects upon the
heart, respiration or vaso-motor centres

SOMNOS (Chemical formula $C_9 H_{11} O_6 Cl_2$) is a definite synthetic compound, formed by the synthesis of chloraethanal with a poly-atomic alcohol radical. It is free from local irritation to mucous membranes and is not changed in the stomach.

SOMNOS produces natural sleep, from which the patient awakens refreshed and free from the unpleasant after-effects noted after other hypnotics. It is safer, more reliable and in every way preferable to chloral hydrate. Its sedative effects upon the nervous system excel those of the bromides.

SOMNOS is indicated in sleeplessness, from whatever cause; in hysteria, neurasthenia, acute infectious diseases, and in chronic organic disease.

INTRODUCED BY

H. K. MULFORD CO.

Chemists

Philadelphia

New York

Chicago

LIBERAL SAMPLE UPON REQUEST

College of Physicians and Surgeons OF BALTIMORE.

FACULTY

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Medical Jurisprudence and Director of Medical Pasteur Institute.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, Toxicology and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, A. B., M. D.,
Professor of Obstetrics.
- WM. ROYAL STOKES, M. D.,
Professor of Pathology and Bacteriology.
- HARRY FRIEDENWALD, A. B., M. D.,
Professor of Diseases of the Eye and Ear.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- C. HAMPSON JONES, M.B., C.M. (EDIN.) M.D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH MCLEARY, M. D.,
Associate Professor of Histology and Pathology.
- CHARLES E. BRACK, PH. G., M. D.,
Associate Professor of Obstetrics.
- JOHN RUHRÄH, M. D.,
Clinical Professor of Diseases of Children.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Clinical Professor of Diseases of the Rectum.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MOGLANNAN, PH. G., M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- MELVIN ROSENTHAL, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- ALBERTUS COTTON, M. D.,
Associate Professor of Orthopedic Surgery.
- ARCHIBALD H. HARRISON, M. D.,
Associate Professor and Demonstrator of Anatomy.
- GLENN M. LITSINGER, PH. G., M. D.,
Demonstrator of Obstetrics.
- A. SAMUELS, PH. G., M. D.,
Demonstrator of Chemistry and Assistant in Genito-Urinary Surgery.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- JOHN MASON KNOX, JR., M. D.,
Demonstrator of Pathology and Physical Diagnosis.
- CHARLES B. CANBY, M. D.,
Demonstrator of Pathology.
- OTTO C. GLASER, A. B.,
Demonstrator of Embryology and Comparative Anatomy.
- L. K. HIRSHBERG, A. B., M. D.,
Demonstrator of Bacteriology and Assistant in Neurology.
- C. W. G. ROHRER, M. D.,
Demonstrator of Pathology.
- L. J. ROSENTHAL, M. D.,
Demonstrator in Clinical Laboratory and Assistant in Diseases of Stomach.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. ULLMAN, M. D.,
Assistant Demonstrator of Anatomy.
- OTTO SCHAEFER, M. D.,
Assistant in Eye and Ear Diseases.
- W. EDWARD MAGRUDER, M. D.,
Assistant in Diseases of Children.
- CHARLES D. STEENKEN, M. D.,
Assistant in Diseases of the Eye and Ear.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Table of Contents Page III.

Issued Quarterly Price \$1.00 per year.

THE JOURNAL
OF THE
ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS
AND SURGEONS
BALTIMORE.

Vol. VI

No. 4

JANUARY, 1904

PUBLISHED AT
Baltimore & Eutaw Sts. Baltimore, Md.

The Pasteur Department of the Baltimore City Hospital

Founded and Controlled by the College of Physicians and Surgeons, Baltimore, Md.

Physician in Chief.—DR. THOS. S. LATIMER.

Director.—DR. N. G. KEIRLE, A. M.

Chief of the Laboratory.—DR. N. G. KEIRLE, JR.

The Pasteur Department of the City Hospital was founded for the preventive treatment of hydrophobia according to the Pasteur method.

The method used is identical with that used in the Institute Pasteur of Paris.

Patients for treatment should come direct to the City Hospital, corner of Saratoga and Calvert Streets.

Patients will be required to remain twenty-one days.

Patients bitten by animals suspected or known to be rabid, should make an especial effort to have the animal kept under observation to determine whether it has rabies.

In case the animal is killed, the whole body, or in case of larger animals the head only, should be sent to the laboratory at the College for investigation. For this purpose it is best to pack it in ice and ship at once by express, prepaid.

Examination of animals that have bitten persons who come for treatment at the Pasteur Department will be made free. In all other cases a moderate charge will be made.

TERMS.—All cases will be charged a uniform price of one hundred and fifty dollars.

For further information address

N. G. KEIRLE, M. D., *Pasteur Department,*

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE, MD.

The Maryland Lying-in Asylum,

113-115 WEST LOMBARD STREET,

BALTIMORE, MD.,

FOR THE CARE OF PUBLIC AND PRIVATE PATIENTS,

WAS ESTABLISHED IN 1874.

The Hospital is conducted according to most modern aseptic methods. Patients, both private and public, are received at any time of the year. The work is conducted under the supervision of the Professor of Obstetrics of the College of Physicians and Surgeons.

For information apply to the

RESIDENT PHYSICIAN,

(Table of Contents on Page iii.)

MARYLAND LYING-IN ASYLUM.

Established 1891.

THE RICHARD GUNDRY HOME,

Catonsville, Baltimore County, Md.



The Richard Gundry Home was established for the treatment of Mental Diseases, selected cases of Alcoholic and Opium habits, and various cases of Nervous Diseases requiring removal from the environments of home. It is also an ideal place for recuperation from exhaustion due to overwork. It is situated on one of the highest elevations in Baltimore County, five hundred feet above the sea level. The buildings are away from the main roads and the Home is quiet and secluded, yet at the same time easily accessible, being but a mile from the prosperous village of Catonsville, Baltimore's most popular suburb. The house is large, well lighted and ventilated, steam heated, sanitary plumbing, and contains all modern improvements. It is surrounded by deep shady porches that are used as promenades for the patients in inclement weather, and as pleasant places to sit during the warmer months.

TREATMENT.—No two cases are exactly alike, and that the fullest benefit be derived from treatment it is necessary that the individual should be studied and the especial needs of each case be supplied. It is the custom at the Home to see that every patient has the treatment and management that long experience and observation has found to be most beneficial.

The greatest liberty commensurate with safety is allowed under the care of a number of competent nurses.

The methods used are those that are characterized by gentle firmness and moral persuasion that appeals to the patient's mind rather than the more obsolete methods of mechanical restraint. In addition to voluntary patients, the Home is duly licensed according to the laws of the State of Maryland to receive patients legally entrusted to it. Rates will be quoted by the Medical Director on receipt of a short outline of the nature of any proposed case. For further information address

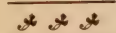
DR. RICHARD F. GUNDRY,
CATONSVILLE, MD.

REFERENCES:

Faculty College of Physicians and Surgeons, Baltimore, Md.
Prof. Wm. Osler, Johns Hopkins Hospital, Baltimore, Md.
Prof. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
Prof. Francis S. Miles, University of Maryland, Baltimore, Md.
Prof. Wm. M. Fontaine, University of Virginia.
Dr. Landon B. Edwards, Richmond, Va.

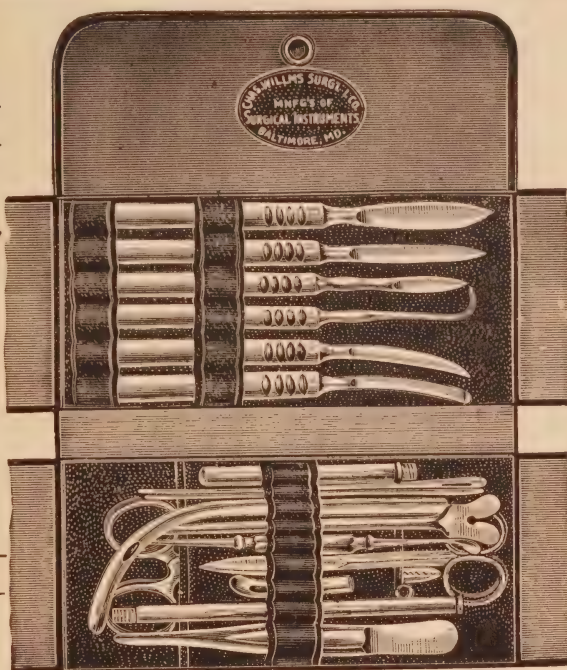
Table of Contents.

	PAGE
The Master-Word in Medicine. DR. WILLIAM OSLER,	97
Tetanus. DR. ISAAC R. TRIMBLE,	109
General Exfoliative Dermatitis. DR. MELVIN ROSENTHAL,	114
Adrenalin in the Treatment of the Cardiac Toxemia of Pneumonia,	120
Editorial,	121
Personal Notes,	iv, 123
Correspondence,	124



**"Our
Leader."**

Have You
Seen It?
The
Best Case
Ever
Offered
At
The Price,
\$5.00.



All
Instruments
Aseptic.
Knives
Hand
Forged.
Each
Blade
Tempered
Separately.



The Chas. Willms Surgical Instrument Co.

MANUFACTURERS AND IMPORTERS,

300 N. Howard Street,

BALTIMORE, MD.

PHYSICIANS', SURGEONS', HOSPITAL AND INVALIDS' SUPPLIES.

Personal Notes.

DR. LOUIS F. HIGH, '91, is the Medical Director of the Pineshire Sanitarium, at Southern Pines, N. C.

DR. W. E. FITCH, '—, is again in medical journalism, in Savannah, Ga. He is now editing "Southern Medicine."

DR. GEORGE M. CUMMINGS '92, has changed his location to Cross Fork, Potter County, Pa. He is a brother of Cummings of '03.

DR. L. M. TIPPETT, '93, is President of the St. Mary's County Medical Society. His post-office is St. Inigoes, St. Mary's county, Md.

DR. JOHN W. MARTIN, '90, of Unionport, Ohio, died at his home on January 10, 1904. Dr. Martin had been ill a long time from tuberculosis.

DR. WILLIAM ANDREW MACMILLAN, '03, was married to Miss Eleanor Graham Owen of this city. As announced in a previous issue the Doctor has settled at Charleston, W. Va.

DOES EVERYTHING

that syrups of hypophosphites do, that is beneficial.

DOES NOTHING

that syrups of hypophosphites do, that is detrimental.

AROMATIC SOLUTION OF HYPOPHOSPHITES

MANUFACTURED BY

HYNSON, WESTCOTT & CO.,

Charles and Franklin Sts.,

BALTIMORE, MD.

Pint samples furnished upon application.

LAPACTIC PILLS

R

Aloin, S. & D.	gr. $\frac{1}{4}$
Strychninae,	gr. $\frac{1}{80}$
Extr. Belladonnae,	gr. $\frac{1}{8}$
Ipecacuanhae,	gr. $\frac{1}{8}$

M: et ft. Pil. No. 1.

The best and most reliable laxative pill ever offered the profession. The formula and name were originated by us, and because of the freedom of our Aloin from any resin of aloes or resinified aloes, due to our manufacturing it ourselves, Lapactic Pills never gripe and never fail. This cannot be said of the many substitutes offered the profession and the trade. Hence, please specify on your prescriptions and orders

SHARP & DOHME

CHICAGO.

BALTIMORE.

NEW YORK.

NEW ORLEANS.

NEW CITY HOSPITAL

Connected with the College of Physicians and surgeons.

NORTH CALVERT STREET, BALTIMORE, MD.



This Institution is owned and conducted by the Sisters of Mercy, and offers special advantages to persons who need medical skill and careful nursing. Patients desirous of having their own family physician attend them are perfectly free to do so. The terms are: For private rooms, \$10.00 to \$25.00 per week; and for private ward, \$5.00. This includes board, medicine and nursing.

Patients needing treatment for the prevention of Hydrophobia are received into the PASTEUR DEPARTMENT of the hospital: here the method of treatment is identical with that used in the Institute Pasteur of Paris.

Connected with the hospital is a *Training School*, where young ladies who wish to adopt nursing as a profession are offered every advantage that can serve to make them skillful nurses. The course of study embraces a period of three years—the lectures are given by the Professors of the *College of Physicians and Surgeons*—and, as the young ladies in training are under the immediate care of the Sisters, nothing is left undone to promote their comfort and well-being.

For full particulars apply to

THE SISTER SUPERIOR.

RESINOL STOPS ITCHING INSTANTANEOUSLY

RESINOL
is a specific for
Pruritus Ani and
Pruritus Vulvæ.

RESINOL
is the best dressing
for Burns, Scalds,
Carbuncles, etc.

R: Ung't Resinol.

Resinol is a prompt local Antiphlogistic in
any form of Dermatitis.

RESINOL
is absolutely Harm-
less, Non-irritating and
Non-poisonous. . . .

RESINOL
is the most effective
remedy known for
Eczema, Herpes and
other skin eruptions

RESINOL
reduces inflammation
on Mucous as well as
Cutaneous Surfaces. .

Samples sent on request.

RESINOL SOAP

is the best Medicated Soap for the Toilet, Bath and Nursery.
It corrects any morbid exudation, removes odor, and nourishes
the skin and underlying tissues.

Water does not irritate if Resinol Soap is used, and it
is the only Soap that will give satisfaction in bathing
eczematous and inflamed surfaces.

RESINOL CHEMICAL CO.,

Branch:
97 New Oxford St.,
London, Eng.

BALTIMORE, MD.

Agents:
Chas. Markell & Co.,
Sydney, N. S. W.

THE JOURNAL
OF THE ALUMNI ASSOCIATION
OF THE
COLLEGE OF PHYSICIANS AND SURGEONS,
BALTIMORE.

THE MASTER-WORD IN MEDICINE.*

BY DR. WILLIAM OSLER,
PROFESSOR OF MEDICINE, JOHNS HOPKINS UNIVERSITY.

Of the value of an introductory lecture I am not altogether certain. I do not remember to have derived any enduring benefit from the many that I have been called upon to hear, or from the not a few that I have inflicted in my day. On the whole I am in favor of abolishing the old custom, but as this is a very special occasion, with special addresses, I consider myself most happy to have been selected for this part of the programme. To the audience at large I fear that much of what I have to say will appear trite and commonplace, but bear with me, since, indeed, to most of you how good so ever the word, the season is long past in which it could be spoken to your edification. As I glance from face to face the most striking single peculiarity is the extraordinary diversity that exists among you. Alike in that you are men and white, you are unlike in your features, very unlike in your minds and in your mental training, and your teachers will mourn the singular inequalities in your capacities. And so it is sad to think will be your careers; for one success, for another failure; one will tread the primrose path to the great bonfire, another the strait and narrow way to renown; some of the

* An address to medical students on the occasion of the opening of the new buildings of the medical faculty of the University of Toronto, Oct. 1, 1903.

best of you will be stricken early on the road, and will join that noble band of youthful martyrs who loved not their lives to the death; others, perhaps the most brilliant among you, like my old friend and comrade, Dick Zimmerman (how he would have rejoiced to see this day!), the Fates will overtake and whirl to destruction just as success seems assured. When the iniquity of oblivion has blindly scattered her poppy over us, some of you will be the trusted counsellors of this community, and the heads of departments in this Faculty; while for the large majority of you, let us hope, is reserved the happiest and most useful lot given to man—to become vigorous, whole-souled, intelligent general practitioners.

It seems a bounden duty on such an occasion to be honest and frank, so I propose to tell you the secret of life as I have seen the game played, and as I have tried to play it myself. You remember in one of the Jungle Stories that when Mowgli wished to be avenged on the villagers he could only get the help of Hathi and his sons by sending them the master-word. This I propose to give you in the hope, yes, in the full assurance, that some of you at least will lay hold upon it to your profit. Though a little one, the master-word looms large in meaning. It is the open sesame to every portal, the great equalizer in the world, the true philosopher's stone which transmutes all the base metal of humanity into gold. The stupid man among you it will make bright, the bright man brilliant and the brilliant student steady. With the magic word in your heart all things are possible, and without it all study is vanity and vexation. The miracles of life are with it; the blind see by touch, the deaf hear with eyes, the dumb speak with fingers. To the youth it brings hope, to the middle-aged confidence, to the aged repose. True balm of hurt minds, in its presence the heart of the sorrowful is lightened and consoled. It is directly responsible for all advances in medicine during the past twenty-five centuries. Laying hold upon it Hippocrates made observation and science the warp and woof of our art. Galen so read its meaning that fifteen centuries stopped thinking and slept until awakened by the *De Fabrica* of Vesalius, which is the very incarnation of the master-word. With its inspiration Harvey gave an impulse to a larger circulation than he wot of, an impulse which we feel to-day. Hunter sounded all its heights and depths, and stands out in our history as one of the great exemplars of its virtues. With it

Virchow smote the rock and the waters of progress gushed out; while in the hands of Pasteur it proved a very talisman to open to us a new heaven in medicine and a new earth in surgery. Not only has it been the touchstone of progress, but it is the measure of success in every-day life. Not a man before you but is beholden to it for his position here, while he who addresses you has that honor directly in consequence of having had it graven on his heart when he was as you are to-day. And the Master-Word is *Work*, a little one, as I have said, but fraught with momentous sequences if you can but write it on the tables of your heart, and bind it upon your foreheads. But there is a serious difficulty in getting you to understand the paramount importance of the work-habit as part of your organization. You are not far from the Tom Sawyer stage with its philosophy "that work consists of whatever a body is obliged to do and that play consists of whatever a body is not obliged to do."

A great many hard things may be said of the work-habit. For most of us it means a hard battle; the few take to it naturally; the enemy prefer idleness and never learn to love to labor. Listen to this: "Look at one of your industrious fellows for a moment, I beseech you," says Robert Louis Stevenson. "He sows hurry and reaps indigestion; he puts a vast deal of activity out to interest, and receives a large measure of nervous derangement in return. Either he absents himself entirely from all fellowship, and lives a recluse in a garret, with carpet slippers and a leaden inkpot; or he comes among people swiftly and bitterly, in a contraction of his whole nervous system, to discharge some temper before he returns to work. I do not care how much or how well he works, this fellow is an evil feature in other people's lives." These are the sentiments of an overworked, dejected man; let me quote the motto of his saner moments: "To travel hopefully is better than to arrive, and the true success is in labor." If you wish to learn of the miseries of scholars in order to avoid them, read Part I, Section 2, Member 3, Subsection XV of that immortal work, the *Anatomy of Melancholy*; but I am here to warn you against these evils, and to entreat you to form good habits in your student days.

At the outset appreciate clearly the aims and objects each one of you should have in view—a knowledge of disease and its cure, and a knowledge of yourselves. The one, a special education, will make you a

practitioner of medicine; the other, an uneducated man, may make you a truly good man, four square and without a flaw. The one is extrinsic and is largely accomplished by teacher and tutor, by text and by tongue; the other is intrinsic and is the mental salvation to be wrought out by each one for himself. The first may be had without the second; any one of you may become an active practitioner, without ever having had sense enough to realize that through life you have been a fool; or you may have the second without the first, and, without knowing much of the art, you may have endowments of head and heart that make the little you do possess go very far in the community. With what I hope to infect you is a desire to have a due proportion of each.

So far as your professional education is concerned, what I shall say may make for each one of you an easy path easier. The multiplicity of the subjects to be studied is a difficulty, and it is hard for teacher and student to get a due sense of proportion in the work. We are in a transition stage in our methods of teachings, and have not everywhere got away from the idea of the examination as the 'be-all and the end-all'; so that the student has constantly before his eyes the magical letters of the degree he seeks. And this is well, perhaps, if you will remember that having, in the old phrase, commenced Bachelor of Medicine, you have only reached a point from which you can begin a lifelong process of education.

So many and varied are the aspects presented by this theme that I can only lay stress upon a few of the more essential. The very first step towards success in any occupation is to become interested in it. Locke put this in a very happy way when he said, give a pupil 'a relish of knowledge' and you put life into his work. And there is nothing more certain than that you cannot study well if you are not interested in your profession. Your presence here is a warrant that in some way you have become attracted to the study of medicine, but the speculative possibilities so warmly cherished at the outset are apt to cool when in contact with the stern realities of the classroom. Most of you have already experienced the all-absorbing attraction of the scientific branches, and nowadays the practical method of presentation has given a zest which was usually lacking in the old theoretical teaching. The life has become more serious in consequence, and medical students have put away many of the child-

ish tricks with which we used to keep up their bad name. Compare the picture of the 'sawbones' of 1842, as given in the recent biography of Sir Henry Acland, with their representatives to-day, and it is evident a great revolution has been effected, and very largely by the salutary influences of improved methods of education. It is possible now to fill out a day with practical work, varied enough to prevent monotony, and so arranged that the knowledge is picked out by the student himself, not thrust into him, willynilly, at the point of the tongue. He exercises his wits, and is no longer a passive Strassbourg goose, tied up and stuffed to repletion.

How can you take the greatest possible advantage of your capacities with the least possible strain? By cultivating system. I say cultivating advisedly, since some of you will find the acquisition of systematic habits very hard. There are minds congenitally systematic; others have a lifelong fight against an inherited tendency to diffuseness and carelessness in work. A few brilliant fellows try to dispense with it altogether, but they are a burden to their brethren and a sore trial to their intimates. I have heard it remarked that order is the badge of an ordinary mind. So it may be, but as practitioners of medicine we have to be thankful to get into this useful class. Let me entreat those of you who are here for the first time to lay to heart what I say on this matter. Forget all else, but take away this counsel of a man who has had to fight a hard battle, and not always a successful one, for the little order he has had in his life—take away with you a profound conviction of the value of system in your work. I appeal to the freshmen especially, because you to-day make a beginning, and your future career depends very much upon the habits you will form during this session. To follow the routine of the classes is easy enough, but to take routine into every part of your daily life is a hard task. Some of you will start out joyfully as did Christian and Hopeful, and for many days will journey safely towards the Delectable Mountains, dreaming of them and not thinking of disaster until you find yourselves in the strong captivity of Doubt and under the grinding tyranny of Despair. You have been over-confident. Begin again and more cautiously. No student escapes wholly from these perils and trials; be not disheartened, expect them. Let each hour of the day have its allotted duty, and cultivate that power of concentration which

grows with its exercise, so that the attention neither flags nor wavers, but settles with a bull-dog tenacity on the subject before you. Constant repetition makes a good habit fit easily in your mind, and by the end of the session you may have gained that most precious of all knowledge—the power to work. Do not underestimate the difficulty you will have in wringing from your reluctant selves the stern determination to exact the uttermost minute on your schedule. Do not get too interested in one study at the expense of another, but to map out your day that due allowance is given to each. Only in this way can the average student get the best that he can out of his capacities. And it is worth all the pains and trouble he can possibly take for the ultimate gain—if he can reach his doctorate with system so ingrained that it has become an integral part of his being. The artistic sense of perfection in work is another much to be desired quality to be cultivated. No matter how trifling the matter on hand, do it with a feeling that it demands the best that is in you, and when done look it over with a critical eye, not sparing a strict judgment of yourself. This it is that makes anatomy a student's touch-stone. Take the man who does his 'part' to perfection, who has got out all there is in it, who labors over the tags of connective tissue and who demonstrates Meckel's ganglion in his part—this is the fellow in after years who is apt in emergencies, who saves a leg badly smashed in a railway accident, or fights out to the finish, never knowing when he is beaten, in a case of typhoid fever.

Learn to love the freedom of the student life, only too quickly to pass away; the absence of the coarser cares of after days, the joy in comradeship, the delight in new work, the happiness in knowing that you are making progress. Once only can you enjoy these pleasures. The seclusion of the student life is not always good for a man, particularly for those of you who will afterwards engage in general practice, since you will miss that facility of intercourse upon which often the doctor's success depends. On the other hand sequestration is essential for those of you with high ambitions proportionate to your capacity. It was for such that St. Chrysostom gave his famous counsel, "Depart from the highways and transplant thyself into some enclosed ground, for it is hard for a tree that stands by the wayside to keep its fruit till it be ripe."

Has work no dangers connected with it? What of this bogie of over-

work of which we hear so much? There are dangers, but they may readily be avoided with a little care. I can only mention two, one physical, one mental. The very best students are often not the strongest. Ill-health, the bridle of Theages, as Plato called it in the case of one of his friends whose mind had thriven at the expense of his body, may have been the diverting influence towards books or the profession. Among the good men who have studied with me there stand out in my remembrance many a young Lycidas, 'dead ere his prime,' sacrificed to carelessness in habits of living and neglect of ordinary sanitary laws. Medical students are much exposed to infection of all sorts, to combat which the body must be kept in first class condition. Grossteste, the great Bishop of Lincoln, remarked that there were three things necessary for temporal salvation—food, sleep and a cheerful disposition. Add to these suitable exercise and you have the means by which good health may be maintained. Not that health is to be a matter of perpetual solicitation, but habits which favor the *corpus sanum* foster the *mens sana*, in which the joy of living and the joy of working are blended in one harmony. Let me read you a quotation from old Burton, the great authority on *morbi eruditorum*. There are "many reasons why students dote more often than others. The first is their negligence; other men look to their tools, a painter will wash his pencils, a smith will look to his hammer, anvil, forge; a husbandman will mend his plough-irons, and grind his hatchet, if it be dull; a falconer or huntsman will have an especial care of his hawks, hounds, horses, dogs, &c.; a musician will string and unstring his lute, &c.; only scholars neglect that instrument, their brain and spirits (I mean) which they daily use." *

Much study is not only believed to be a weariness of the flesh, but also an active cause of ill-health of mind, in all grades and phases. I deny that work, legitimate work, has anything to do with this. It is that foul fiend Worry who is responsible for a large majority of the cases. The more carefully one looks into the causes of nervous breakdown in students, the less important is work *per se* as a factor. There are a few cases of genuine overwork, but they are not common. Of the causes of worry in the student life there are three of prime importance to which I may briefly refer.

*Quotation mainly from Marsilius Ficinus.

An anticipatory attitude of mind, a perpetual forecasting, disturbs the even tenor of his way and leads to disaster. Years ago a sentence in one of Carlyle's essays made a lasting impression on me: "Our duty is not to *see* what lies dimly at a distance, but to *do* what lies clearly at hand." I have long maintained that the best motto for a student is, "Take no thought for the morrow." Let the day's work suffice; live for it, regardless of what the future has in store, believing that to-morrow should take thought for the things of itself. There is no such safeguard against the morbid apprehensions about the future, the dread of examinations and the doubt of ultimate success. Nor is there any risk that such an attitude may breed carelessness. On the contrary, the absorption in the duty of the hour is in itself the best guarantee of ultimate success. "He that regardeth the wind shall not sow, and he that observeth the clouds shall not reap," which means you cannot work profitably with your mind set upon the future.

Another potent cause of worry is an idolatry by which many of you will be sore let and hindered. The mistress of your studies should be the heavenly Aphrodite, the motherless daughter of Uranus. Give her your whole heart, and she will be your protectress and friend. A jealous creature, brooking no second, if she finds you trifling and coquetting with her rival, the younger, earthly Aphrodite, daughter of Zeus and Dione, she will whistle you off and let you down the wind to be a prey, perhaps to the examiners, certainly to the worm regret. In plainer language, put your affections in cold storage for a few years, and you will take them out ripened, perhaps a bit mellow, but certainly less subject to those frequent changes which perplex so many young men. Only a grand passion, an all-absorbing devotion to the elder goddess can save the man with a congenital tendency to philandering, the flighty Lydgate who sports with Celia and Dorothea, and upon whom the judgment ultimately falls in a basil-plant of a wife like Rosamond.

And thirdly, one and all of you will have to face the ordeal of every student in this generation who sooner or later tries to mix the waters of science with the oil of faith. You can have a great deal of both if you only keep them separate. The worry comes from the attempt at mixture. As general practitioners you will need all the faith you can carry, and while it may not always be of the conventional pattern, when expressed in

your lives rather than on your lips, the variety is not a bad one from the standpoint of St. James; and may help to counteract the common scandal alluded to in the celebrated diary of that gossipy old parson-doctor, the Rev. John Ward: "One told the Bishop of Gloucester that he imagined physitians of all other men the most competent judges of all others affairs of religion—and his reason was because they were wholly unconcerned with it."

Professional work of any sort tends to narrow the mind, to limit the point of view and to put a hall-mark on a man of a most unmistakable kind. On the one hand are the intense, ardent natures, absorbed in their studies and quickly losing interest in everything but their profession, while other faculties and interests 'rust' unused. On the other hand are the bovine brethren, who think of nothing but the treadmill and the corn. From very different causes, the one from concentration, the other from apathy, both are apt to neglect those outside studies that widen the sympathies and help a man to get the best there is out of life. Like art, medicine is an exacting mistress, and in the pursuit of one of the scientific branches, sometimes, too, in practice, not a portion of a man's spirit may be left free for other distractions, but this does not often happen. On account of the intimate personal nature of his work, the medical man, perhaps more than any other man, needs that higher education of which Plato speaks,—“that education in virtue from youth upwards, which enables a man eagerly to pursue the ideal perfection.” It is not for all nor can all attain to it, but there is comfort and help in the pursuit, even though the end is never reached. For a large majority the daily round and the common task furnish more than enough to satisfy their heart's desire, and there seems no room left for anything else. Like the good, easy man whom Milton scores in the *Areopagitica*, whose religion was a “traffic so entangled that of all mysteries he could not skill to keep a stock going upon that trade” and handed it over with all the locks and keys to “a divine of note and estimation,” so is it with many of us in the matter of this higher education. No longer intrinsic, wrought in us and ingrained, it has become, in Milton phrase, a “dividual movable,” handed over nowadays to the daily press or to the hap-hazard instruction of the pulpit, the platform or the magazines. Like a good many other things, it comes in a better and more enduring form if not too consciously sought.

The all-important thing is to get a relish for the good company of the race in a daily intercourse with some of the great minds of all ages. Now, in the spring-time of life, pick your intimates among them, and begin a systematic cultivation of their works. Many of you will need a strong leaven to raise you above the level of the dough in which it will be your lot to labor. Uncongenial surroundings, an ever-present dissonance between the aspirations within and the actualities without, the oppressive discords of human society, the bitter tragedies of life, the *lacrymae rerum*, beside the hidden springs of which we sit in sad despair—all these tend to foster in some natures a cynicism quite foreign to our vocation, and to which this inner education offers the best antidote. Personal contact with men of high purpose and character will help a man to make a start—to have the desire, at least, but in its fulness this culture—for that word best expresses it—has to be wrought out by each one for himself. Start at once a bed-side library and spend the last half hour of the day in communion with the saints of humanity. There are great lessons to be learned from Job and from David, from Isaiah and St. Paul. Taught by Shakespeare you may take your intellectual and moral measure with singular precision. Learn to love Epictetus and Marcus Aurelius. Should you be so fortunate as to be born a Platonist, Jowett will introduce you to the great master through whom alone we can think in certain levels, and whose perpetual modernness startles and delights. Montaigne will teach you moderation in all things, and to be “sealed of his tribe” is a special privilege. We have in the profession only a few great literary heroes of the first rank, the friendship and counsel of two of whom you cannot too earnestly seek. Sir Thomas Browne’s *Religio Medici* should be your pocket companion, while from the Breakfast Table Series of Oliver Wendell Holmes you can glean a philosophy of life peculiarly suited to the needs of a physician. There are at least a dozen or more works which would be helpful in getting that wisdom in life which only comes to those who earnestly seek it.

A conscientious pursuit of Plato’s ideal perfection may teach you the three great lessons of life. You may learn to consume your own smoke. The atmosphere of life is darkened by the murmurings and whimperings of men and women over the non-essentials, the trifles that are inevitably incident to the hurly burly of the day’s routine. Things cannot always

go your way. Learn to accept in silence the minor aggravations, cultivate the gift of taciturnity and consume your own smoke with an extra draught of hard work, so that those about you may not be annoyed with the dust and soot of your complaints. More than any other the practitioner of medicine may illustrate the second great lesson, that we are here not to get all we can out of life for ourselves, but to try to make the lives of others happier. This is the essence of that oft-repeated admonition of Christ, "He that findeth his life shall lose it, and he that loseth his life for my sake shall find it," on which hard saying if the children of this generation would only lay hold, there would be less misery and discontent in the world. It is not possible for any one to have better opportunities to live this lesson than you will enjoy. The practice of medicine is an art, not a trade, a calling, not a business, a calling in which your heart will be exercised equally with your head. Often the best part of your work will have nothing to do with potions and powders, but with the exercise of an influence of the strong upon the weak, of the righteous upon the wicked, of the wise upon the foolish. To you as the trusted family counsellor the father will come with his anxieties, the mother with her hidden grief, the daughter with her trials and the son with his follies. Fully one-third of the work you do will be entered in other books than yours. Courage and cheerfulness will not only carry you over the rough places of life; but will enable you to bring comfort and help to the weak-hearted and will console you in the sad hours when, like Uncle Toby, you have "to whistle that you may not weep."

And the third great lesson you may learn is the hardest of all—that the law of the higher life is only fulfilled by love or charity. Many a physician whose daily work is a daily round of beneficence will say hard things and will think hard thoughts of a colleague. No sin will so easily beset you as uncharitableness towards your brother practitioner. So strong is the personal element in the practice of medicine, and so many are the wagging tongues in every parish, that evil speaking, lying and slandering find a shining mark in the lapses and mistakes which are inevitable in our work. There is no reason for discord and disagreement, and the only way to avoid trouble is to have two plain rules. From the day you begin practice never under any circumstances listen to a tale told to the detriment of a brother practitioner. And when any dispute or trouble

does arise, go frankly, ere sunset, and talk the matter over, in which way you may gain a brother and a friend. Very easy to carry out, you may think! Far from it; there is no harder battle to fight. Theoretically there seems to be no difficulty, but when the concrete wound is rankling and after Mrs. Jones has rubbed in the cayenne pepper by declaring that Dr. J. told her in confidence of your shocking bungling, your attitude of mind is that you would rather see him in purgatory than make advances towards reconciliation. Wait until the day of your trial comes and then remember my words.

And in closing may I say a few words to the younger practitioners in the audience whose activities will wax not wane with the growing years of the century which opens so auspiciously for this school, for this city and for our country. You enter a noble heritage, made so by no efforts of your own, but by the generations of men who have unselfishly sought to do the best they could for suffering mankind. Much has been done, much remains to do; a way has been opened, and to the possibilities in the scientific development of medicine there seems to be no limit. Except in its application, as general practitioners you will not have much to do with this. Yours is a higher and a more sacred duty. Think not to light a light to shine before men that they may see your good works; contrariwise, you will join the great army of quiet workers, physicians and priests, sisters and nurses, all over the world, the members of which strive not neither do they cry, nor are their voices heard in the streets, but to them is given the ministry of consolation in sorrow, need and sickness. Like the ideal wife of whom Plutarch speaks, the best doctor is often the one of whom the public hears least; but nowadays in the fierce light that beats upon the hearth it is increasingly difficult to live the secluded life in which our best work is done. To you the silent workers of the ranks, in villages and country districts, in the slums of our large cities, in the mining camps and factory towns, in the homes of the rich and in the hovels of the poor—to you is given the harder task of illustrating in your lives the old Hippocratic standards of Learning, of Sagacity, of Humanity and of Probity. Of Learning that you may apply in your practice the best that is known in our art, and that with the increase in your knowledge there may be an increase in that priceless endowment of Sagacity, so that to all everywhere skilled succor may come

in the hour of urgent need. Of a Humanity that will show in your daily life tenderness and consideration to the weak, infinite pity to the suffering and a broad charity to all. Of a Probity that will make you under all circumstances true to yourselves, true to your high calling and true to your fellow men.

TETANUS.*

BY DR. ISAAC R. TRIMBLE.

In 1884 Nicolaier described the bacillus of tetanus, and in 1889 Kitasato obtained it in pure culture. It is one of the most poisonous of known bacteria. The bacilli, when not in spore formation, are long and slender and have rounded ends. They are motile and seldom united in chains. At the temperature of the body they form spores, and when in spore formation there is an enlargement at one end of the bacillus, in the center of which there is a bright round spore. They have no flagella, and while in spore formation they are non-motile. They stain with the ordinary anilin dyes and by Gram's method.

It is a common, saprophytic organism and is found in garden earth, dust, especially of stables, and sometimes in the intestines and discharges of animals. It is difficult to isolate and grows only where oxygen has been displaced. Kitasato's method of obtaining it in pure culture is the one generally used. It consists of heating the cultures to 80° C. for an hour at a time. This is sufficient to kill all contaminating organisms, but does not kill the tetanus spores, which may be subsequently cultivated under suitable conditions. The cultures all have a peculiar, rather characteristic odor.

Verneuil has observed that tetanus rarely occurs at sea, and when it does it occurs on vessels carrying hay or dirt. Ledantec has noted the fact that the natives in the New Hebrides poison their arrows by dipping them in clay rich in tetanus bacilli.

The bacillus generally gains entrance into the body through a punctured wound or an open one that has been badly soiled. The period of incubation is from 7 to 28 days, and during this period the wound may

* Read before the Journal Club, November, 1901.

heal and not be found on examination. Men, horses, mice and rabbits are very susceptible to this bacillus, while dogs and birds are but slightly so. Amphibians are immune, but frogs may be infected if the body temperature is raised.

The bacillus grows at the site of inoculation, but does not enter the blood-current and is very rarely found in the body. Its growth is most rapid and but few bacilli are required to produce a most powerful toxin. The following experiments need no word of comment:

Kitasato inoculated the tail of a mouse, and an hour later tail, skin and subcutaneous tissue about the root of the tail were cut away. In spite of this the mouse died of tetanus.

Nocard took three sheep and put under the skin at the root of the tail of each a splinter of infected wood. When the first symptoms appeared he cut off the tails of two of the sheep, keeping the third as a control. All three died of tetanus.

Mice may be killed by injecting into them the blood, urine, or cerebrospinal fluid of animals affected with tetanus.

Brieger separated from the blood of diseased animals and also from pure cultures of the tetanus bacillus two alkaloid substances which he calls tetanin and tetanotoxin. Both are poisonous and capable of producing convulsions. Brieger and Fraenckel later isolated an extremely powerful toxalbumin. Vaillard and Rouget found that when tetanus bacilli were injected into the body free from toxin, owing to the promptness with which the phagocytes took them up and destroyed them, there were no ill effects. If the tissues were injured, however, either from trauma or chemicals, the bacilli began to form toxins and symptoms resulted.

Pehring and Kitasato, and subsequently many other observers, have produced a valuable antitoxin by the usual method of introducing into animals increasing doses of the toxin. A. Lambert has shown that a protective power of 1 to 800,000,000 can be obtained. Dr. Welch has pointed out that antitoxin has not as yet been very successful in the treatment of human tetanus. In animals it has proved of great value as a preventive. In all laboratories where horses are injected with the various toxins there is invariably an outbreak of tetanus from time to time. If

the animals are given tetanus antitoxin every three months these outbreaks are prevented. This has been shown to be so at the Mulford Laboratories in Philadelphia.

Nocard's figures regarding protective inoculations are most striking. Of 2,727 animals inoculated not one developed tetanus, while during the same period in the same neighborhood 256 non-immunized animals developed the disease. In the large lying-in hospitals where tetanus is present its spread may be prevented by giving the mothers an immunizing dose of the antitoxin.

The more acute the attack the less chance there is of cure. The prognosis depends on the period of incubation and the nature of the attack. Roux and Borelles assert that the mortality in severe cases is 50% when the injections are made in the subcutaneous tissue. Delayed cases may result in cure with or without the use of antitoxin. In those individuals in whom the disease develops before five days after infection, the prognosis is almost invariably fatal. I do not know of a case of the patient getting well when the disease developed within four days. All cases coming on after five days may be classed as delayed, and they have a correspondingly good prognosis, depending, of course, on the incubation period.

The treatment is to open the wound and cleanse it thoroughly, with the object of preventing the formation of more toxin. Blood may be drawn and the fluid in the body replaced by injecting normal salt solution. The antitoxin should be injected as soon as possible. It has been suggested by Rabbe that the antitoxin would be more powerful and quick in its action if it were injected directly into the cerebral cavity. To do this it would be necessary to trephine. A simpler plan is to inject it into the spinal canal, using the same procedure as for lumbar puncture. Subcutaneous injection seems, so far, to give about equally good results.

Carbolic acid has been recommended by many. The idea originated with Bacelli, and has attracted widespread attention in Italy, where the most brilliant results are claimed for it. It has not received very much attention elsewhere, although there are a few scattered reports, some by very good authorities, commending its use. The drug is given hypodermically, the dosage being about 0.2 cc. (3 minims) in 2% solution, given during 24 hours. Twice as much as this and even more has been given

without bad results. The injections are usually given at two-hour intervals. I have had no personal experience with its use.

In former days the surgical treatment of tetanus consisted in cleansing the wound, nerve stretching, or even amputation of the member wounded, at the first sign of the disease. Today the treatment consists in thorough cleansing of the wound, administration of antitoxin, and the use of such drugs as may be deemed necessary for allaying unpleasant symptoms.

The dosage of antitoxin should be considered carefully and a sufficient quantity used. When tetanus first shows itself it has probably existed for some days in a latent stage, and with the use of antitoxin there is an alleviation of the unpleasant features in many cases, and in some of the delayed cases a cure may be effected. Let me refer briefly to my experience with this disease:

While I was a student of medicine at the Maryland University, a boy of 12 years came in with a crushed foot. The late Dr. J. E. Michael amputated the leg, and 10 day later the boy developed tetanus. We gave him whiskey, milk and opium by rectum and by mouth. Chloroform was used to lessen the spasms. The case was one of delayed tetanus, and after an illness of three weeks the boy recovered.

In April, 1892, a stableman was kicked on the leg by a horse. A compound fracture of the tibia and the fibula was the result. The wound was cleansed and dressed. Four days later tetanus developed. Six days after the injury I amputated the leg above the knee, but without effect on the course of the disease. The man died on the seventh day after infection.

In 1894 a man fell down an areaway and sustained a compound comminuted fracture of the left shoulder bones. The wound was carefully cleansed and dressed. Seven days later the first symptoms of tetanus showed themselves, and 36 hours later the man died. The ordinary treatment was without avail.

In 1898 a negro was admitted to the City Hospital suffering from a wound of the foot of five days' standing. Tetanus had already developed. The wound was opened and cleansed and he was given a full dose of morphia and tetanus antitoxin hypodermically. During the following week he was given 700 cc. of the serum. He recovered and was able to leave the hospital in a month.

In 1900 a white woman came into the City Hospital. She had had spasms of the jaws for two weeks, was emaciated, and much reduced in health. She was given antitetanic serum and improved. Unfortunately the spasm was never relieved entirely, and she died of exhaustion four weeks later.

During the same year I was called to see an old man who had fallen in the street two weeks previously, receiving a cut on the head. The wound had been dressed by the family physician. On the ninth day tetanus developed. When I saw him he had been having convulsions for five days. He was given three phials of the antitoxin, but without result. He died 12 hours later.

In 1901 a negro who had served in the U. S. Army at Santiago, and who had had both yellow fever and rheumatism at that time, came to my office. Two hours before he had been thrown from his wagon into the street. The palm of his right hand at the base of his middle finger was torn across exposing the tendons. There was dirt in the wound and in the tendon sheath. He regarded the wound as trivial and came only because urged to do so by his employer. The finger was cocainized and laid open. It was cleansed thoroughly and then allowed to soak in 1-5000 bichlorid solution for 15 minutes. As the wound did not heal readily, and there was some suppuration, it was opened again and hydrogen dioxid used in cleansing it. Ten days later the wound was practically healed, only a small part of it granulating. On the thirteenth day the patient told me that his right shoulder pained him and that he thought he had a return of the rheumatism with which he had suffered while a soldier. Tetanus was not suspected at this time. I was called to see him two days later, and he presented all the characteristic symptoms of tetanus. He was moved to the City Hospital, and placed in a darkened room and kept absolutely quiet. The convulsions were very severe, some lasting so long that it was feared he would die from impeded respiration. Chloroform was used to relax him, and he was given three phials of antitoxin which relieved him in a half hour, so that he was able to take nourishment. For 10 days he was given the serum every six hours. At first three phials were given at a dose, later two, and at the end of the treatment only one. Within 10 days he was given 53 phials of antitoxin. His spasms ceased but the muscles remained stiff and sore. He continued to improve, and was discharged cured at the end of six weeks.

From the foregoing cases and those of other observers I am led to believe that the tetanus antitoxin is of very considerable value in the treatment of this disease, especially in the delayed cases.

GENERAL EXFOLIATIVE DERMATITIS.

By DR. MELVIN ROSENTHAL.

It is to be deplored that dermatology with its very many difficulties of diagnosis should be burdened with a nomenclature not alone fearfully and wonderfully made but frequently inexpressive, obscure and misleading. The fault lies largely in the existence of a number of "Schools" each of which has solved for itself at least, a permanent classification and a system of diagnosis. The older writers drew their deductions from clinical appearances, placing microscopic findings as of minor importance. The later writers, led by Unna, make the microscopic changes all important and give to the clinical picture secondary consideration. The happy medium of giving to each its just share of importance is being developed by the American dermatologist and it is to be earnestly hoped that in the near future the enormous mass of unnecessary phrasing, duplication of terms, redundancy of words to express similar processes may be eliminated, and out of the chaos a permanent nomenclature for cutaneous diseases may be established.

Exfoliating dermatitis or pityriasis rubra (Hebra) furnishes a good example of the foregoing statement. American and English dermatologists use the terms synonymously, a few making the distinction that pityriasis rubra represents a so-called primary type, and exfoliating dermatitis designates a secondary type. By primary type is inferred a universal dermatitis characterized by redness, scaling, moderate itching, in the absence of any pre-existing lesion or inflammation. The secondary type is consequent to an established inflammation of the skin such as eczema, pemphigus, lichen planus, etc. Since both types make their appearance in some localized area and spread from its point of invasion some slowly, others more rapidly, assuming new characteristics as it progresses, a consideration of the primary seat of inflammation would lead to a discussion of whether or not this area may be considered as a local dermatitis. This in turn would bring up the *bete noire* of dermatology, as to what is meant by eczema, on which question dermatologists agree to disagree.

The objection of the Germans to the term exfoliating dermatitis is that it represents a process common to a large number of diseases and not a disease with a distinct cycle of symptoms. The condition is found common in psoriasis, squamous eczema, following the use of irritants, rhus poisoning, etc., and whilst the process may extend and involve large areas, even become universal, it is still nothing more or less than an extension of the original area and deny it separate recognition because of this involvement. For pityriasis rubra, on the other hand, is claimed as not being dependent on any pre-existing inflammation—although the original site of the disease is indistinguishable from an ordinary localized eczema.

The following case of exfoliative dermatitis is especially of interest from the fact of a complete recovery having taken place, the patient after a number of years was again exposed to the same predisposing factor as produced the first attack, and was soon thereafter seized with a violent recurrence.

W. W., age 32; white; married; laborer; American; ad.—

Family History.—Father died of tuberculosis; otherwise history good.

Previous History.—Patient had measles and scarlet fever as a child. No history or evidences of venereal disease.

Four years ago, while working in a brick yard as a laborer, he was frequently exposed to very high temperature. The exposure was but for a short time lasting for 5 to 10 minutes, but frequently repeated during the day. After about 6 weeks the patient noticed an eruption of hands and head. The eruption consisted of pronounced redness, with but slight itching and moderate scaling. It did not interfere with his work, and in a few weeks the condition had involved the entire integument. The only inconvenience suffered in the early stage was the unsightliness, and the slight itching. Later the patient was annoyed by the dryness of the skin with subsequent fissuring and profuse scaling.

He was admitted to City Hospital, Sept. 6, 1898, with a universal dermatitis, skin intensely red, thin and shiny and a general exfoliation of the skin. He was discharged January 2, 1899, almost well, a few isolated patches being the only evidence of the disease. Worked on a farm for several months, during which time he remained perfectly well.

About a year ago he returned to work at the brick yard and was subjected to the same influence which produced the first attack. After a few

months, during which time he avoided as far as possible exposure to the high temperature, an eruption appeared on the hands and feet. This outbreak had the same characteristics as the first attack, and in a few weeks the skin over the entire body was involved. He continued at his work for several months, when the pain caused by the fissured skin compelled him to seek medical advice.

On admission the patient was found to be literally incased in a thick crust of some oily substance and the debris from the exfoliation. He had not bathed for months and it was only after a vigorous application of a hot bath and soap, that the condition of the skin could be noted. The entire skin was a deep red, and not unlike the proverbial boiled lobster. There was not the slightest area uninvolved. Deep fissures in the plexuses of elbow, axilla, and knees restricted movements of the limbs. The skin was thin, shiny, and drawn tightly, with a decidedly leathery feel. The scales were fine, bran-like and in great profusion, rapidly reforming. The hair on head was almost entirely lost, the slightest traction removing it. The beard, eyebrows, axilla and pubes remained unaffected. The nails were affected with decided thickening and fissuring. Ectropion of the eyelids with pus infection was a troublesome feature. The skin was dry, except in the localities where fissuring had taken place. The mucous membranes were not involved. Inability to use the limbs freely with the slight itching and an extreme sensitiveness to cold were the only subjective symptoms. The general health was good. There was apparently no interference with the normal function of the body. The urine contained a trace of albumen for several weeks. There were no casts.

The condition remained stationary for several months and very gradually the redness slowly disappeared, the scaling has become less, the fissures healed and the skin is resuming its normal color and consistency.

The treatment consisted in keeping the skin anointed with salicylic acid and olive oil, the removal of the scales by bicarbonate baths and the internal administration of arsenic.

This picture represents the usual type of the exfoliating dermatitis. The initial symptoms, which are not noted in the above case, resemble malaria. There is a decided chill followed by malaise, headache, vomiting and not infrequently a rise in temperature. Some localized area

shows evidences of inflammation remaining local for from one to three weeks and then spreading to the entire integument.

This inflammation is of an erythematous type and spreads as such. There is at no time present in the early stage evidences of papule, vesicle or pustule. The redness is rapidly followed by scaling. Infiltration in the early stage is absent but may be a prominent symptom in the later stage. The redness disappears on pressure, leaving behind a yellow spot. The scales are ordinarily fine, bran like, of a grayish tinge, and rapidly reform in enormous quantities. The hair and nails are generally affected in the course of the disease and temporarily lost. The nails frequently remain deformed and fissured long after the disease subsides.

In the later stage of the disease the skin loses its elasticity due to infiltration and atrophy and the formation of fissures and contractures of the limbs is not uncommon. Ectropion of the lower eyelid is also frequent. The patients are extremely susceptible to changes in temperature. Itching at no time is prominent. The ordinary health of the patient is usually not interfered with, unless the process is protracted or active movement restricted, in which case the patient's normal resisting power may be lowered. The symptoms gradually decline and complete recovery is the rule. This recovery is not permanent, as subsequent attacks are frequent.

Etiology is obscure. Jadassohn has drawn attention to the presence of tuberculosis in most of the reported cases. Mackensie, Crocker and others have attributed it to gouty and rheumatic diathesis. Others still have suggested nerve changes as the responsible factor.

Pathology.—In the Archives für Dermatologie und Syphilis, July, 1901, Kopytowske and Wielowieyski give the result of their investigation as follows: "Inflammatory changes were observed in the papillary body and in the upper of the corium. These consisted in a diffuse cellular infiltration with a few underlying foci composed of leucocytes, connective tissue cells and occasional giant cells. The hair follicles and sebaceous glands were atrophied. Here and there in the corium were peculiar 'miliun' bodies. In the epidermis the granular layer was defective. The cells of the horny layer were imperfectly united, but the Malpighian layer was definitely thickened. In the final stage of the disease the cellular infiltration was replaced by newly formed fibrous

tissue. Diplococci were grown from scrapings of the skin, and were also present in the sections."

Diagnosis.—Fortunately there are but few skin diseases marked by complete involvement of the entire epidermis. A number of diseases characterized by diffuse redness, itching and scaling closely resemble exfoliating dermatitis but in none of them do we find the condition universal. A careful examination will reveal areas of normal skin, a point which distinguishes them from the disease under consideration.

Acute psoriasis has much in common with exfoliating dermatitis. It is, however, never complete. There is a history of an eruption on the extensor surfaces, antedating the outbreak. Removal of the scales shows small punctate, hemorrhagic spots, the dilated capillaries exuding a drop of blood. Lichen ruber is distinctly papular throughout its course; from beginning to end it is marked by the persistence of the papule. It is not universal and while the nails are affected, the hair does not suffer.

The disease so closely resembles the erythematous type of eczema that many authors are inclined to classify it under this head. The differential points are in eczema; there is no tendency to atrophy of the skin; there is marked itching; the formation of vesicles, papules and pustules is common; we can usually get a history of some oozing or secreting surface; there is no involvement of the hair.

Treatment.—The most important part of the treatment consists in the local application of oils and salves to keep the skin soft and pliable and to relieve the irritation.

The body should not only be anointed with the oils, but clothes soaked with it should be in continual contact. The addition of 1 to 3 grs. of carbolic acid to the ounce will tend to relieve the slight itching. Salicylic acid in the same proportion assists in removing the tightly adherent scales. The use of warm alkaline baths adds to the comfort of the patient. Vaseline with the addition of carbolic or salicylic acid is of special service on face and head where continual bandaging is not practicable.

Except for special symptoms internal treatment is of no avail. Arsenic, quinine, pilocarpine and sodium salicylate have been at various times advocated but their direct influence on the course of the disease is doubtful.

DR. THOMAS W. BROCKBANK, '85, in the *New York Medical Journal* gives some points on the care and use of the static machine. One important point is that all static machines are affected by atmospheric conditions and that moisture within the machine is one of the constant sources of trouble. This moisture can best be taken up by placing a dish of thoroughly dried ferric chloride of lime inside the machine for an hour or more. To keep the outside of the machine thoroughly dry in damp weather a bunsen burner is placed under the machine. All external parts, including electrodes, sliding poles, connecting rods, chairs, etc., should be kept clean and brightly polished. The platform should be kept clean and should have solid glass legs at least ten inches high. Even a thin film of dust on the legs of the platform will act as a conductor and impair results.

Another point is the matter of grounding. This grounding must be metallic. For the machine he bores a small hole in the floor through which a brass chain is passed; to this is attached a copper wire, and this wire in turn is connected with the gas pipe. On the free end of the chain a hook is attached by which to connect it with the sliding pole which is not in use.

For the electrodes a copper wire is stretched across the office, one end of which is connected to the water pipe. To this wire is attached the active electrode by means of a brass chain with a hook on each end. By this means a perfect system of grounding and consequent increased therapeutic effect is obtained.

DR. MURPHY, of Chicago, has been experimenting with a solution of rubber as a coating for the hands as a substitute for rubber gloves. He finds that a 4 per cent solution of pure rubber in benzine acts well. After the hands are washed in the usual manner they are coated with the rubber solution, which dries in three or four minutes. This thin coating is not affected by soap and water or bichloride solutions. It can be readily removed by benzine.

ADRENALIN IN THE TREATMENT OF THE CARDIAC
TOXEMIA OF PNEUMONIA.

The writer, Henry L. Elser, M. D., of Syracuse, N. Y. (*New York Medical Journal*, January 2, 1904), directs attention to the appalling mortality of pneumonia due to the resulting cardiac toxemia. The prime factor in this disease is a toxemia with obstruction in the pulmonary circuit, leading to cardiac asthenia. Marked changes occur in the right half of the heart, with far-reaching degenerative changes in the muscle, heart-clots, and vasomotor paralysis.

Three remedies meet the indications presented by the circulatory changes due to paralysis of the vasomotor centers, the dilated condition of the arteries, and the weakened heart. These are strychnine, digitalis, and suprarenal extract or adrenalin, its active principle. Adrenalin acts on the heart and blood vessels favorably; it does not act on the vasomotor center. Hence, it may be used to assist strychnine. When the vasomotor center is exhausted and blood-pressure study proves the inefficiency of strychnine, adrenalin may still be administered, and, in some cases which seem unpromising, when combined with the method of stimulation about to be suggested, we may carry the patient beyond the critical period to a safe recovery. Suprarenal extract, or adrenalin, has seemed to the author to act as a needed food in all infections where there is danger of myocardial degeneration. He reports a case of pneumonia in a woman, the mother of five children, in whom it had been impossible to raise a continually lowering blood-pressure with strychnine. The systolic blood-pressure was almost immediately raised by the repeated administration at short intervals of fifteen minims of a one-to-one-thousand solution of adrenalin hypodermically, and the patient was saved.

WILLIAM S. GARDNER, M. D., EDITOR,
6 W. Preston Street,
JOHN RUHRÄH, M. D., ASSOCIATE EDITOR,
839 N. Eutaw Street.

WILLIAM J. TODD, M. D., BUSINESS MANAGER,
Mt. Washington.
Telephone, C. & P., Tuxedo, 984.

THE JOURNAL

OF THE ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

A NEW PHYSICAL SIGN.

It is refreshing to run across something which is new in medicine or at any rate comparatively new. We are so apt to believe that all the easy things have been seen and heard and then some one comes along and shows us that we have been seeing or hearing something all our days and never perceived it. So it was when Litten called attention to the diaphragm phenomenon which is so frequently spoken of in connection with his name. So it was when Dr. Remouchamps, one of the Hospital Physicians at Gand, wrote in one of the recent journals his article on "Laryngeal Crepitation, a Sign of Pulmonary Tuberculosis." (*"La crepitation laryngée, signe de tuberculose pulmonaire," in La Semaine Médicale, December 2, 1903.*)

This is a new sign and we do not know anything of its value except what Dr. Remouchamps has been pleased to write. We will state however that it can be heard but we have not had sufficient time to study its value in a number of cases. The sign consists of the crepitation which is produced in the lung tissue which has been invaded by the tuberculous process. This crepitation is transmitted through the bronchi to the larynx where it is considerably amplified and thence out of the mouth. To observe this sign stand or sit in front of your patient. For convenience place your right hand on the patient's left shoulder and your left thumb on his chin holding his mouth about half way open. Approach your left ear to the patient's mouth and listen about five to ten centimeters away.

One hears in tuberculosis a fine crepitation which may be likened to the scratching of a fine pen on paper. It is heard during inspiration and expiration and is usually heard most plainly on expiration. The crepitation remains during the entire disease and sometimes is heard more plainly than at others, varying with the intensity of the disease and disappearing if the lesion disappears. Sometimes it can be heard at a distance of fifty centimeters or more and sometimes it may be heard even with the mouth shut. Dr. Remouchamps has heard it when a patient was talking to him in his consultation room. It was then heard between the words, and the diagnosis of pulmonary tuberculosis was made before the patient had mentioned anything about his disease. Subsequent examination proved the correctness of the observation. He claims that it is of especial value in the diagnosis of early tuberculosis.

Tuberculosis seems to be the only disease where it is heard constantly. It may be heard in some cases where there is bronchitis in the upper part of the lungs but the other signs of bronchitis are also present and it is not constant as it is in tuberculosis. It is also heard during attacks of asthma. It is not heard in pneumonia (lobar) nor in congestion nor cedema of the lung.

The sign was mentioned once before for its value in making the diagnosis of cavity in the lung. This was by Cybulski (H. Cybulski, "*Ein Beitrag zur Diagnose der Lungen-Kavernen*," *Münch. Med. Wochenschr.*, 4 Nov. 1902.)

This will be a good subject for investigation by the members of the Alumni Association and we shall be pleased to hear the observations concerning it.

R.

THE MASTER WORD IN MEDICINE.

It gives us great pleasure to say that Dr. Osler has kindly consented to our reprinting the major portion of one of his characteristically charming addresses in this issue of the Journal. We want every reader of the Journal to read and enjoy this sermon for young physicians and medical students which is really what it is. The older members of our Alumni Association we are sure will be no less pleased than the younger ones, to whom this Toronto Address was primarily intended.

Dr. Osler is a great believer in work and practices what he preaches in this regard. It is from his own success that he is led to think "*Work*" the Master-Word in Medicine. After you have read his address you will think so too, if you had any doubt of it before. But good wine needs no bush and Dr. Osler's address needs no comment.

R.

SUBSTITUTES FOR SUGAR IN DIABETES.

Various substances are used to sweeten the food and drink of the diabetic. Many of these are sold under special names, as "Crystallose" and "Diabetin." Preparations of inulin, of inosite, of mannite and of fruit sugar have also been suggested as being less injurious than ordinary sugar.

Glycerin is sometimes used, but has many opponents, among them Senator and Frerichs. It leaves a sweet taste in the mouth, and may have a decided laxative effect.

Saccharin (benzoyl-sulphonic-imide) is very much used. It has an excessively sweet taste and may be procured in tablets which equal in sweetening power an ordinary lump of sugar. If taken in quantities not exceeding five grains a day it is perfectly harmless. The following is a much-quoted formula given by James Stewart:

Saccharingr. xlv

Sodium bicarbonate siccagr. xxx

Mannitedrachms xiiss

Make one hundred pastilles. One will sweeten a cup of coffee.

Garantose (sodium benzoyl-sulphonic-imide, Heyden) is a much more soluble preparation.

Dulcin (paraphenatolcarbamid, Heyden) is much used in Germany for sweetening the food and drink of diabetics and is recommended by many of the best authorities. In small quantities such as are used it is harmless, but in large quantities that have been given experimentally it causes symptoms (icterus, etc.). More than half a gram (8 gr.) should not be given in any one day. It may be procured in tablets containing 0.025 gram each. Each of these has the sweetening power of an ordinary lump of sugar. Some patients prefer the taste of it to that of saccharin and *vice versa*.

Saxin is another coal tar product used to sweeten food for the diabetic. It may be obtained in tablet form. It is said to be six hundred times sweeter than sugar, and many patients prefer its taste to that of the other preparations.

Personal Notes.

DR. A. S. PRIDDY, —, of Roanoke, Va., is in the city doing some post-graduate work. Dr. Priddy is one of the Board of Examiners for Virginia and has served several terms in the State Legislature.

The funeral of Mrs. Estelle Cloonan, wife of Dr. John J. Cloonan, of Stamford, Conn., took place yesterday afternoon from Union Station. Mrs. Cloonan was a daughter of the late James McMahon, of Baltimore, and formerly resided at 661 West Franklin street. Her death was sudden, and her infant child died a few hours before her. Mrs. Cloonan's mother and brother, James McMahon, resided in Stamford.

DR. JOSEPH IRWIN FRANCE, '03, was married to Mrs. Evelyn S. Tome of Port Deposit, Md. Dr. and Mrs. France have their town house at 1311 North Charles Street and their country place at Port Deposit. Dr. France is assisting in the Neurological Department of the City Hospital and is Demonstrator of Anatomy at the Women's Medical College. He is also attending some of the courses at the Johns Hopkins Hospital.

DR. JOHN H. SCALLY, '—, died at Towson, Md., January 22, 1904, after a lingering illness. His last days were spent at the Eudowood Hospital for Consumptives, near Towson. Dr. Scally was 33 years of age, and at one time was in active practice in Baltimore county. He was a graduate of the Maryland College of Pharmacy, and after his graduation was one of the resident physicians for some time at Spring Grove Asylum. A few years ago the doctor removed to Baltimore city and opened an office at 1809 East Baltimore street. He was appointed Coroner for the Northeastern District by Governor Smith, which office he held up to the time of his death. He is survived by two brothers and a sister. The funeral was from St. Patrick's Church and interment was in the Holy Cross Cemetery.

DE MAN WID DE PILLS.

BY HENRY EDWARD WARNER.

W'en de worl' look black an' de clouds hang low

An' yo' feel lak yo' gwine t' die—

W'en yo' pulse beat fas' er yo' pulse beat slow,

An' dah's sickness in yo' eye,

Don' was' no time wid er fool black man

Dat's givin' advice fo' yo' ills,

But hustle away as fas' as yo' can

Fo' de man wid de li'l roun' pills.

W'en you git so sick dat yo' cyarn't stan' straight,

An' de roomytiz lan's in yo' back—

W'en yo' feel lak de whole worl' movin' late,

An' yo' bones lak dey gwine t' crack,

Don't stop fo' t' lis'en t' no brass ban',

Thinkin' ragtime'll cure yo' ills,

But git on de move fo' de medisun man

Wid he grip full ob li'l roun' pills!

W'en de fevah burn an' de chill git in

Wid a cordial an' hearty shake,

An' you' heart am a-thumpin' lak holy sin,

Go an' git you' sump'n t' take;

Dis life's jess a short an' fleetin' span,

An' hit's full ob provokin' ills—

W'en dey comes yo' way run fas's yo' can

Fo' de man wid de li'l roun' pills.

An' de man wid de pills come, an' den he put

He han' on yo' pulse, jess so,

An' he rub an' rub wid he rabbit foot

'Twell de pains an' de aches all go;

So don't lose time wid a fool black man

Dat's givin' advice fo' yo' ills,

But hustle away as fas' as yo' can

Fo' de man wid de li'l roun' pills.

—*The Evening News.*

THE DELAY OF THIS NUMBER.

The JOURNAL is not dead. We have received several more or less anxious inquiries as to whether it was or not. We have to crave the indulgence of our subscribers who pay; and those who are in arrears—well, they can wait too once in a while.

Our printer-man burnt out. Not in the big fire, but in one all his own, much earlier. There was necessarily some delay, and then came the conflagration which paralyzed everything for awhile, and the JOURNAL did not escape the general loss of action.

But here we are at last, and we hope that there will be no trouble in the future.

JOHN RUHRÄH, M. D., Baltimore, Md.

Dear Doctor Ruhräh: Perhaps you will be a bit interested in my new home, and while waiting for something "to turn up," as Micawber used to say, will give you some idea of the place.

The hospital is situated in the upper part of the city on high ground, and is a very large building built on the letter "H" plan, and occupies a whole block. There are sixteen wards and each ward affords twenty-one beds. They are nearly filled all the time, giving us plenty of material; in fact, too much, as there are but five men on the staff.

We take a new interne every four months, the service being divided as follows: Four months, junior surgeon and pathologist; four months, junior physician; four months, senior surgeon; four months, house physician; four months, house surgeon.

My present work consists of all anæsthetics, the pathological examinations, the contagious service and ambulance service every other night and afternoon.

The ambulance service is active. We have three fine ambulances and do all the work for the city. It is conducted on the New York "hurry" style.

The training in anæsthesia is excellent. There is a professional anæsthetizer who instructs all the new men. Most of our work is done with nitrous oxide gas and oxygen and then ether. We use all kinds of inhalers and get a thorough training in best methods (open and closed).

Another good feature of the place is that the Health Department Laboratory is in the building and we have full access to it. Dr. Connelly, the bacteriologist, is a fine fellow and an experimenter, and helps us along. The diphtheria and sepsis antitoxin for the city is made here, and also a tubercule antitoxin which we are using here in our tubercular ward. The Health Department are doing their best for the tuberculars and working on the basis that most tuberculosis have a mixed infection. We are injecting a series of cases with sepsis antitoxin, and find the night sweats let up and appetite improves and the patients have a better chance to fight the tuberculosis.

We also have a fine X-ray laboratory, and Dr. Irving, who is in charge, is trying to treat tuberculosis by passing ozonized silver through the chest by cataphoresis. So you see there is quite a little of interest.

One ward is devoted to maternity work and another to children.

Whenever you come to New York, or anywhere near Newark, be sure and come to see me. With best wishes,

Sincerely,

EDWARD W. SPRAGUE.

DR. CHAS. E. BRACK, Baltimore, Md.

My Dear Brack: Enclosed please find check for my subscription to the ALUMNI JOURNAL. "The plaint of the Treasurer."

I was somewhat chagrined to learn that by your "ever watchful care" you "manage somehow to keep the JOURNAL out of debt, but only by saving at every turn."

Keep dodging Brack and you will soon have the art of finance down a la Morgan.

They accused you "of trying to extort money from the needy, of embezzling, of having a desire to take a trip to Canada, and of many other things." (?)

You "hard-worked, unpaid, much-maligned," upright, "but fortunately" honest Brack! You are having a harder road to travel than most treasurers, and it behooves the Alumni to come to your rescue with baskets of flowers to strew before you to make your pathway more pleasant.

With the greatest sympathy for our plaintive Treasurer, I remain,

Sincerely yours,

J. M. LEONARD, '00.

DERBY, CONN.

My Dear Brack: Just a line to let you know that Donovan is still living, and after twenty months of hospital work has located. After graduating in April, 1902, I took the exams for appointment at St. Vincent's Hospital, New York, and made second place, and say, wasn't the New York boys hot to think a P. & S. man from Baltimore got in. I stayed there one year and then took the exams for an appointment at Bellevue Hospital and made that, too. I stayed six months and then took the exams for the New York Lying-in; got that, stayed two months there and come up for the Connecticut State Board; got by that and here I am, located in my own town and only been open seven days. I have had sixteen calls and eight office calls. If it keeps up, which I feel it will, I expect to do well. The population is 30,000. I have three rooms, and I can assure you they are fitted out right up to date.

Say, there is nothing like hospital work, especially when you have Brayent, Bull, McBurney, Janeway, Delifield, Felps, Smith, and those fellows to make rounds with. I suppose you will get tired of this letter, but I thought I would give you an outline of what a member of the class of 1902 of P. & S. done. Be sure to send the ALUMNI JOURNAL to my address and don't forget to send me a bill, for I have only paid one dollar since I have been receiving it.

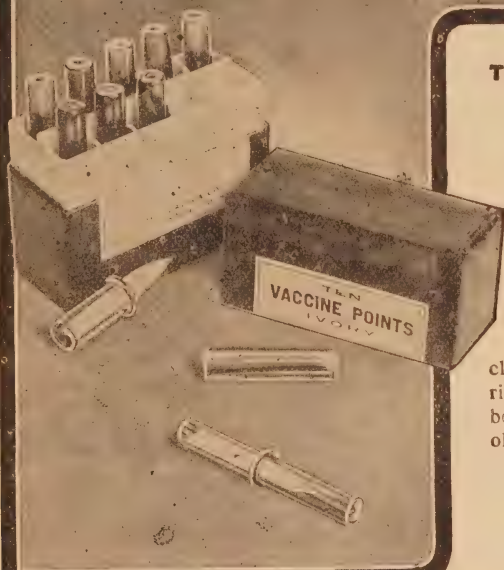
I am very sincerely yours,

S. F. DONOVAN, '02.

VACCINE

(GLYCERINATED)

BACTERIOLOGICALLY & PHYSIOLOGICALLY TESTED



THE

PERFECT VACCINE

must be free from taint of sepsis. It must be active.

Parke, Davis & Co.'s Glycerinated Virus meets these requirements.

The scientific methods used in its preparation preclude any other result. Its purity and activity are established beyond question by rigid bacteriological and physiological tests.

TUBES AND POINTS

Our Glycerinated Vaccine is supplied in **Capillary Glass**

Tubes, hermetically sealed, in boxes of 10 tubes and 3 tubes; also in **Points**, each point in a Lee's patent breakable glass tube, 10 points in a box.

ALWAYS SPECIFY "PARKE, DAVIS & CO." WHEN ORDERING.

PARKE, DAVIS & COMPANY

LABORATORIES: DETROIT, MICH., U.S.A.; WALKERVILLE, ONT.; HOUNSLOW, ENG.

BRANCHES: NEW YORK, CHICAGO, ST. LOUIS, BOSTON, BALTIMORE, NEW ORLEANS, KANSAS CITY, MINNEAPOLIS, INDIANAPOLIS, MEMPHIS; LONDON, ENG.; MONTREAL, QUE.; SYDNEY, N.S.W.; ST. PETERSBURG, RUSSIA; SIMLA, INDIA; TOKIO, JAPAN.

The Baltimore College of Dental Surgery.

CHARTERED BY THE LEGISLATURE OF MARYLAND IN 1839.

THE OLDEST DENTAL COLLEGE IN THE WORLD.

Faculty.

M. WHILLDIN FOSTER, M. D., D. D. S., Professor of Therapeutics and Pathology.
 WM. B. FINNEY, D. D. S., Professor of Dental Mechanism and Metallurgy.
 B. HOLLY SMITH, M. D., D. D. S., Professor of Dental Surgery and Operative Dentistry.
 THOMAS S. LATIMER, M. D., Professor of Physiology and Comparative Anatomy.
 WILLIAM SIMON, Ph. D., M. D., Professor of Chemistry.
 CHARLES F. BEVAN, M. D., Clinical Professor of Oral Surgery.
 J. W. CHAMBERS, M. D., Professor of Anatomy.
 WILLIAM F. LOCKWOOD, M. D., Professor of Materia Medica.

Lecturers.

WILLIAM F. SMITH, A. B., M. D., Regional Anatomy.
 R. BAYLY WINDER, Pharm. G., D. D. S., Materia Medica.
 EDW. HOFFMEISTER, Ph. D., D. D. S., Materia Medica.
 J. N. FARRAR, M. D., D. D. S., Irregularities.
 DR. GEORGE EVANS, Crown and Bridge-work.
 KASSON C. GIBSON, New York, Oral Deformities and Fractured Maxillaries.
 JOHN WALTERHOUSE LORD, A. B., LL. B., Counsel and Lecturer
 on Dental Jurisprudence.

Clinical Instructors.

T. S. WATERS, D. D. S., Chief Clinical Instructor, Resident, Md.

CORYDON PALMER, D. D. S.....	Ohio.	H. A. PARR, D. D. S.....	N. Y.
E. PARMLEY BROWN, D. D. S.....	N. Y.	J. EMORY SCOTT, D. D. S.....	Md.
A. L. NORTROP, D. D. S.....	N. Y.	C. L. ALEXANDER, D. D. S.....	N. C.
E. L. HUNTER, D. D. S.....	N. C.	M. M. MAINE, D. D. S.....	Conn.
W. W. WALKER, D. D. S.....	N. Y.	J. W. DAVID, D. D. S.....	Texas.
OSCAR ADELBURG, D. D. S.....	N. J.	A. C. BREWER, D. D. S.....	Md.
G. MARSHALL SMITH, D. D. S.....	Md.	J. ROACH, D. D. S.....	Md.
C. M. GINGRICH, D. D. S., Resident.....	Md.	J. HALL MOORE, D. D. S.....	Va.
R. B. DONALDSON, D. D. S.....	D. C.		

Demonstrators.

WILLIAM G. FOSTER, D. D. S., Demonstrator of Operative Dentistry.
 GEO. D. HARDY, M. D., D. D. S., Demonstrator of Mechanical Dentistry.
 EDW. HOFFMEISTER, Ph. D., D. D. S., Demonstrator of Chemistry.

Assistant Demonstrators.

WILLIAM G. FOSTER, D. D. S.	GEORGE D. HARDY, M. D., D. D. S.
EDW. HOFFMEISTER, PH. D., D. D. S.	W. W. DUNBRACCO, D. D. S.
L. M. PARSONS, D. D. S.	GEO. V. MILHOLLAND, D. D. S.
J. K. BURGESS, D. D. S.	H. M. LEVER, D. D. S.
HARRY E. KELSEY, D. D. S.	C. R. STEWART, D. D. S.
L. F. PALMER, D. D. S.	J. C. SUTHERLAND, D. D. S.
S. B. GRIMES, M. D.	CHAS. THEBERATH, D. D. S.
	C. H. CARSON, D. D. S.
	C. S. GORE, D. D. S.
	L. D. COBIELL, D. D. S.
	A. C. HARRISON, M. D.
	S. G. DAVIS, M. D.

The Sixty-Fourth Annual Session will commence on the 1st of October, 1903, and continue until May, 1904.

The Infirmary is open during the entire year for Dental Operations.

Students corresponding with the Dean will please be careful to give full address, and direct their letters to

M. W. FOSTER, M. D., D. D. S., Dean,

9 WEST FRANKLIN STREET, BALTIMORE, MD.

College of Physicians and Surgeons OF BALTIMORE.

FACULTY

- ABRAM B. ARNOLD, M. D.,
Emeritus Professor of Clinical Medicine.
- THOMAS OPIE, M. D.,
Professor of Gynecology and Dean of the Faculty.
- THOMAS S. LATIMER, M. D.,
Professor of Principles and Practice of Medicine and Clinical Medicine.
- CHARLES F. BEVAN, M. D.,
Professor of Principles and Practice of Surgery, Clinical and Genito-Urinary Surgery.
- WM. SIMON, PH. D., M. D.,
Professor of Chemistry.
- J. W. CHAMBERS, M. D.,
Professor of Surgical Anatomy, Operative and Clinical Surgery.
- GEORGE J. PRESTON, A. B., M. D.,
Professor of Physiology and Diseases of the Nervous System.
- N. G. KEIRLE, A. M., M. D.,
Professor of Medical Jurisprudence and Director of Pasteur Institute.
- WILLIAM F. LOCKWOOD, M. D.,
Professor of Materia Medica, Therapeutics, Toxicology and Clinical Medicine.
- ISAAC R. TRIMBLE, M. D.,
Professor of Anatomy and Clinical Surgery.
- GEORGE W. DOBBIN, A. B., M. D.,
Professor of Obstetrics.
- WM. ROYAL STOKES, M. D.,
Professor of Pathology and Bacteriology.
- HARRY FRIEDENWALD, A. B., M. D.,
Professor of Diseases of the Eye and Ear.
- EDWARD N. BRUSH, M. D.,
Professor of Psychiatry.
- C. HAMPSON JONES, M. B., C. M. (EDIN.)
M. D.,
Professor of Hygiene, Public Health and Clinical Medicine.
- JULIUS FRIEDENWALD, A. M., M. D.,
Clinical Professor of Diseases of the Stomach and Director of the Clinical Laboratory.
- WILLIAM S. GARDNER, M. D.,
Associate Professor of Gynecology.
- FRANK DYER SANGER, M. D.,
Clinical Professor of Diseases of Nose, Throat and Chest.
- STANDISH McCLEARY, M. D.,
Associate Professor of Histology and Pathology.
- CHARLES E. BRACK, PH. G., M. D.,
Associate Professor of Obstetrics.
- JOHN RUHRÄH, M. D.,
Clinical Professor of Diseases of Children.
- H. H. HAYDEN, M. D.,
Associate Professor of Human and Comparative Anatomy.
- CHARLES F. BLAKE, M. D.,
Associate Professor of Surgery and Clinical Professor of Diseases of the Rectum.
- SAMUEL J. FORT, M. D.,
Associate Professor of Materia Medica and Pharmacology.
- DANIEL BASE, PH. D.,
Associate Professor of Chemistry.
- ALEXIUS MCGLENNAN, PH. G., M. D.,
Associate Professor of Physiological Chemistry and Demonstrator of Physiology.
- HARVEY G. BECK, M. D.,
Associate Professor of Clinical Medicine and Demonstrator in Clinical Laboratory.
- THOMAS R. BROWN, A. B., M. D.,
Associate Professor of Clinical Medicine.
- J. HALL PLEASANTS, A. B., M. D.,
Associate Professor of Clinical Medicine.
- CARY B. GAMBLE, JR., A. B., M. D.,
Associate Professor of Clinical Medicine.
- MELVIN ROSENTHAL, M. D.,
Associate Professor of Genito-Urinary Surgery and Dermatology.
- ALBERTUS COTTON, M. D.,
Associate Professor of Orthopedic Surgery.
- ARCHIBALD H. HARRISON, M. D.,
Associate Professor and Demonstrator of Anatomy.
- GLENN M. LITSINGER, PH., G., M. D.,
Demonstrator of Obstetrics.
- A. SAMUELS, PH., G., M. D.,
Demonstrator of Chemistry and Assistant in Genito-Urinary Surgery.
- W. W. REQUARDT, M. D.,
Demonstrator of Surgery.
- G. W. MITCHELL, M. D.,
Demonstrator of Diseases of Nose, Throat, Chest and Osteology.
- H. C. KNAPP, M. D.,
Demonstrator in Clinical Laboratory.
- JOHN MASON KNOX, JR., M. D.,
Demonstrator of Pathology and Physical Diagnosis.
- CHARLES B. CANBY, M. D.,
Demonstrator of Pathology.
- OTTO C. GLASER, A. B.,
Demonstrator of Embryology and Comparative Anatomy.
- L. K. HIRSBERG, A. B., M. D.,
Demonstrator of Bacteriology and Assistant in Neurology.
- C. W. G. ROHRER, M. D.,
Demonstrator of Pathology.
- L. J. ROSENTHAL, M. D.,
Demonstrator in Clinical Laboratory and Assistant in Diseases of Stomach.
- SAMUEL BUTLER GRIMES, M. D.,
Assistant Demonstrator of Anatomy.
- S. G. DAVIS, M. D.,
Assistant Demonstrator of Anatomy.
- A. ULLMAN, M. D.,
Assistant Demonstrator of Anatomy.
- OTTO SCHAEFER, M. D.,
Assistant in Eye and Ear Diseases.
- W. EDWARD MAGRUDER, M. D.,
Assistant in Diseases of Children.
- CHARLES D. STEENKEN, M. D.,
Assistant in Diseases of the Eye and Ear.

This school having adopted the four years' graded course of study in 1895, is now well established on this plan.

The minimum requirement of the Association of American Medical Colleges and most State Boards of Examiners, beginning with 1898, is four full sessions of six months each in four separate years. In view, therefore, of the increased time and expense of a medical education, this school has abandoned the Preliminary Course of Lectures hitherto given.

The College and Hospital facilities comprise: The College Building proper, the Baltimore City Hospital, the Hospital for the Colored Race, the Maternité Hospital, Bay View Hospital.

For further information, address

PROFESSOR THOMAS OPIE, M. D., Dean,

CALVERT AND SARATOGA STREETS,

BALTIMORE, MD.

Table of Contents Page III.



